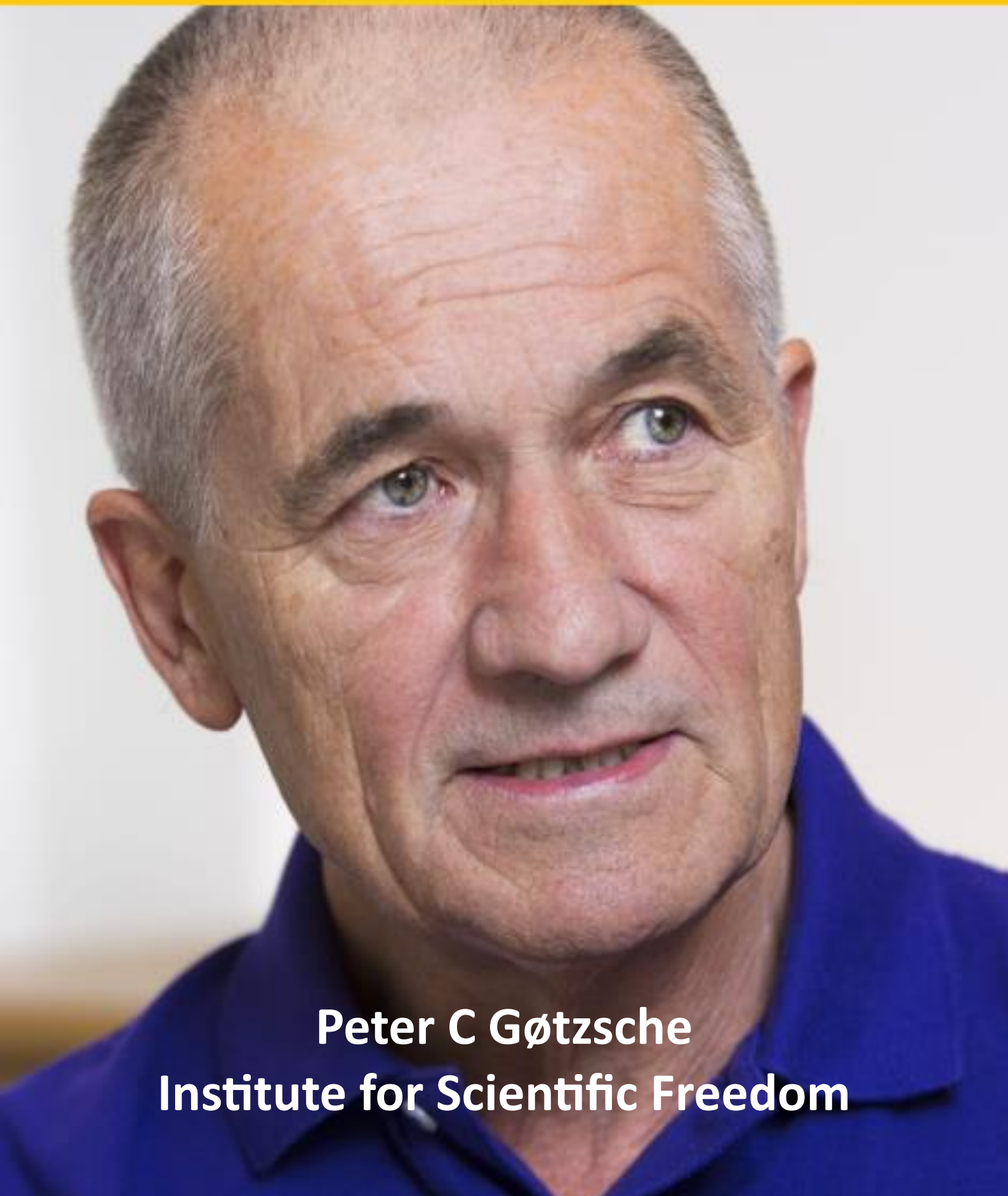
# Whistleblower in healthcare



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# Whistleblower in healthcare

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# Abbreviations

CDC: Centers for Disease Control and Prevention, USA
CET: Cochrane Central Executive Team
CI: 95% confidence interval (the true result is 95% likely to lie within this interval)
DSM: Diagnostic and Statistical Manual of Mental Disorders, from USA
ECT: Electroconvulsive therapy
FDA: Food and Drug Administration, USA
GSK: GlaxoSmithKline
NEJM: New England Journal of Medicine
NGO: Non-governmental organisation
NHS: National Health Service, UK
NIMH: National Institute of Mental Health, USA
NNH: Number needed to treat to harm one patient
NNT: Number needed to treat to benefit one patient
OCD: Obsessive-Compulsive Disorder
SSRI: Selective Serotonin Reuptake Inhibitor
WHO: World Health Organization

# Preamble: What this book is about and why I wrote it

The emperor's new clothes

HC Andersen's fairy tale, *The emperor's new clothes*, is my favourite, as it illustrates so well what most of the healthcare literature is about: deception. The authorities are often willing to lie about the evidence and they continue lying when you point this out to them, as authorities can never be wrong, right?

If you document that the emperor has no clothes, and you threaten financial, guild or political interests, you might be exposed to primitive and mendacious attacks, including attempts at character assassination, and you might be fired. My life as a whistleblower illustrates these elements. I was fired even though I had saved many lives and billions in healthcare expenditure. My book is a horror story about a healthcare that is focused on power and money, and on torturing the data till they confess.

I was an explorer and a pioneer and often came in trouble only because I was the first to demonstrate that the emperor had no clothes.

It never occurred to me that I should write an autobiography, but when historian, and one of Denmark's best documentary filmmakers, Janus Bang from Fredericia, declared in November 2023 at an early breakfast in Stanford, when we were both severely jetlagged, that he wanted to write a historical biography about me, I had no choice. There was so much he would not know about if I didn't write it down first.

I had a lot to say. As the only Dane, I have published over 100 papers – in widely different areas - in "the big five" medical journals (*BMJ*, *Lancet*, *JAMA*, *Annals of Internal Medicine* and *New England Journal of Medicine*). My research seems to have had some impact, as it has been cited over 190,000 times, and there have been at least 16 comments about it in *Science* and *Nature*.[1]

People listened. I was on a list of the 100 most powerful people in Denmark in healthcare for many years and number 2 on a list of those with the highest professional reputation in 2003.[2] When I turned 50, Danish public TV devoted half an hour to interviewing me in prime time about why Danish doctors often prescribe expensive and useless drugs based on doubtful research, fully or partly financed by the big drug companies.[3] I got a nice email from Kirsten Lee, the wife of our Minister of Foreign Affairs, Niels Helveg Petersen, saying

Niels was pleased with the interview and felt I had been diplomatic. I mention this because it is one of the few occasions that someone called me diplomatic.

I have helped the media write many of their stories, but when they portrayed me at my major birthdays, they were not overly kind. When I turned 50, an industry-funded magazine had the headline: *An intelligent fighting cock: Peter Gøtzsche's eternal hunt for "the truth" often brings him in opposition to colleagues, authorities and the drug industry*.[4] Well, think about it. That's because - as a journalist wrote in relation to my findings about mammography screening - that nothing hurts like the truth about healthcare[5] where so many have so much to hide.

The headlines in major newspapers when I turned 60 were: *He bites big pharma in the hamstrings*,[6] and *Uncompromising doctor.*[7] When I turned 70, they were: *The drug industry's tormentor continues his fight for the truth*;[8] *A controversial scientist*;[9] and *Respected and disputed at the same time*.[10] There was agreement that I divided the waters but also that I was "one of the most prominent experts and debaters in the ongoing discussion about drug effects."[11] When I met with Robert F Kennedy Jr., the current US Minister of Health, in 2019, he said that he had wanted to see me because he regarded me as the world's foremost critic of the drug industry.

When I turned 75, a newspaper brought a comprehensive portrait of me, mostly laudatory, but already in the headline, the journalist got it wrong: *Peter Gøtzsche was one of the greatest. Until his manners knocked him off the throne*. I explained in the same newspaper that what knocked me over was one of the worst show trials in academic history (see page 350).[12]

I have done research in many different areas and journalists have sometimes asked me why I have taken up so many issues. I have responded by quoting Picasso. Why did he paint in so many different styles; what was he looking for? Picasso replied: I don't look for things, I find them. This is what explorers do. They see things others overlook or don't want to face and they try to help people who cannot cut through all the hype themselves.

In 2016, when I got the HealthWatch Award[13] for my detective work in healthcare and was invited to London to receive it, I started my talk this way:[14]

"People ask me, why do you look for controversies? And I tell them, I don't, they come to me. My work is something like that of a medical detective. People come to me if they feel something is wrong in healthcare. When I start looking into these issues, I usually dig very deep. I find skeletons, and when I expose these skeletons, the people who buried them can get very angry."

I didn't stop there. I have been very active as a communicator, as I find it of utmost importance to tell the patients what is wrong with healthcare so that they can better protect themselves against harm.

# 1 My first 25 years as a sceptical explorer and adventurer

My arrival wasn't planned. I was the result of a warm goodbye in February 1949. My father embraced my mother in the doorway to the house where she lived with her parents, and I came into being, not in the missionary position, as indigenous people called it, but in the standing position.

I was born on 26 November 1949 in Copenhagen. My mother, Marianne Fibiger Gøtzsche, was a schoolteacher. She lectured in mathematics and housework, and my father, Kjeld Bundgaard, studied medicine at first and then theology. They met via mutual friends.

My grandfather, Poul Christian Gøtzsche, was a family doctor. He was keenly aware of the impending signs of schizophrenia in his coming son-in-law, which my mother ignored because she loved him so much. To separate them, he arranged for my mother to be sent to Switzerland as a nanny in a wealthy family in Bern for a year.

As soon as she came back, she renewed the relationship, and my father made her pregnant for the second time. The first time, my grandfather had arranged for an abortion, even though this was illegal back then. He now reasoned he couldn't go on like this, exposing himself to a possible criminal charge and loss of reputation. But he was very concerned that his daughter was going to have a baby with a man who would likely develop schizophrenia.

My life has been endangered many times, and, as you can see, already *in utero*, but a marriage was hastily arranged, and I arrived six months later.

Already during the pregnancy, my father developed serious schizophrenia of the catatonic type and became hospitalised for many years. When my mother visited him at Sct. Hans Hospital and presented me to him, there was no contact. They divorced a couple of years later, and she moved to Næstved to work as a schoolteacher.

There, she met another divorced schoolteacher, Børge Jensen, moved into his house at Katholmvej 11 and remarried.

The marriage was happy in the beginning but Børge never accepted me as his own son. Later in life, I joked that if I had grown up in a bear or lion family, I would have been killed by the male. That's how he was.

The coldness of my stepfather influenced me greatly, many years into adulthood. But he couldn't break me. I was a strong child.

I did my utmost to obtain Børge's love but failed. He was a big man, and one day, when I wanted to compare the size of his hands with mine, he fobbed me off with an insulting remark. My classmates had noticed my big hands and subjected me to a "beer test." I was the only one who could embrace a bottle of beer so that my thumb met with the middle finger.

Børge was a tyrant. He used people. Everything in our family revolved around him and his needs. He could be extremely charming when he wanted to obtain something, for example to get a blacksmith down the road repair his coal fired boiler for a small sum and no receipt. He had two children from a previous marriage, which was arranged after he had made one of his pupils pregnant.

Børge was very fond of the child he got with my mother, Lea, but she also suffered from his manners. So much, that she needed help from a psychologist who succeeded to set her free from his influence when she was about 60 years old, ten years after he died. The sessions ended with Lea screaming out loudly to get him out of her system.

At age 4, I came very close to dying again. We lived just 150 metres from the boat club, two kilometres outside town. I played with a girl and a boy in the wintertime, and we went down to the canal. The girl was envious at me because I was better than her at rolling a rusty bicycle wheel with a stick.

To be better than others is a recurrent theme that has had considerable consequences for me, particularly in my professional life. This time, it almost cost me my life.

When standing on the bridge where the boats were moored, the girl suddenly pushed me forward and both kids ran away. I went through the ice and came up again but there was no way I could save myself. I couldn't reach for the bridge, which was too high up, and I couldn't climb ashore under the bridge, as there wasn't room for it.

Næstved boat club in 1966

My first day at school

I don't believe in miracles, but it was extremely unlikely that I would survive this. The area was very desolate in wintertime, but exactly at this moment, when I only had a few more minutes left to live, a man walked by in the street along the canal 30 metres away. The boy called out to him, and he ran down to the canal and rescued me.

He brought me home and left. My mother was too shocked to react rationally. She didn't take his address and was therefore unable to thank him later. She wrote in her diary that she put me in a metallic bathtub with hot water and scrubbed me with a towel, but I continued to shatter my teeth for a long time beneath her quilt. She also wrote:

"We knew that someone had looked after you. Imagine, if no one had come by, you would have sunk to the bottom before your playmate had reached our house. But when you were told it was God's angel that had looked after you and had saved you, you said: 'No, it was the man!' And when you had finished your story, you said: 'And mom, then I drank so much water, but not it all; there is still some left in the canal!!' Yes, you had certainly swallowed a good deal, but we thanked God that you came over it so well. But after this you got whooping cough, which was not nice."

The pertussis was so horrible that I still remember how difficult it was to breathe during the coughing fits where I sounded like a sea lion. This was before there was a vaccine. I also got measles, chickenpox and mumps. The pain from my enlarged salivary glands was so intense that I cried a lot. I could not eat or smile without experiencing excruciating pain.

Back then, my mother was religious, like her parents whose fathers had both been priests. One, Andreas Fibiger, was famous for having collected so much money from wealthy

people that it allowed him to pay for a new church, the Elias Church, which was built on Vesterbro's Square in a poor area of Copenhagen. He wrote many books about religious subjects that sold in large numbers and was also a popular radio priest. The other priest, Erik Gøtzsche, was an architect and a military man before becoming a missionary to India. He lived for some years in Madras, now Chennai, where my grandfather was born.

I have never believed in anything for which there was no evidence, and at about the same age, I declared to my playmates that Santa Claus didn't exist. I was beaten up by an older boy whose only arguments were his hard-hitting fists.

When my mother was pregnant with Lea, we didn't know if she expected a girl or a boy. She wrote in her diary:

"When I went to my first examination at the midwife, you said: 'Are you now going to get him out?' 'No, not yet, not before he is big enough.' 'How will he then get out?' Then, I told you a little about this, and you said: 'Then you must remember to take him home from the clinic!' One evening, when I stood in the kitchen and prepared food for you, you suddenly said: 'Do you know how many we are out here?' 'No.' 'We are three, you and me and the little guy in your stomach.'"

When the little guy turned out to be a girl, I was disappointed that it was "only a girl," because I had looked forward to playing football with my little brother. As it were, Lea later became a member of a football club but in 1955, girls didn't play football.

My mother wrote about me: "You have a very loving mind and kindly share with us when you have something. You buy things for your pocket money and come home and share it with us or your playmates. But you are also stubborn, and if I scold you, you become very angry and insulted and regret that you gave me a piece of chocolate the other day, 'You will never again get anything,' you say, but quickly forget it. On 26 April, you were bitten by a dog (a German Shepherd) that knocked you over on the pavement and ripped off totally one of the sleeves in your windbreaker, but luckily, you were only superficially wounded. It could have been terrible what might have happened. You, who are so afraid of dogs, took it surprisingly sensibly. Afterwards, you said to me: 'I should have gone the other way; then it would not have happened.'"

Although I didn't believe in the existence of gods, I once threatened with divine retaliation after my playmates had teased me: "I will tell it to God when I go to Heaven!"

It defies reason to think there is a god up there, in the sky. And why is it always a man, not a woman, and why only one and not many? And what does a god do for leisure, being totally alone, according to Christian myths? People who believe in gods should read *The god delusion* by biologist Richard Dawkins.

Let's get down to earth and talk about something basic and real: uncontrollable erections. Why do male autobiographies never say anything about this? It was a huge problem for me, and I cannot be the only one. On the Internet, there is a funny video about the "restless penis syndrome," which can be treated with Dequip pills.[15]

The first erection I can remember came when I was five years old and played with my playmates. I had no idea about what it was and was terrified. I thought there was something badly wrong with me and hid the embarrassing bulging in a hedge till it disappeared.

During car trips with my parents, I got erections when the road was bumpy. I tried to concentrate on something else, but it didn't work out. I therefore wore long sweaters even in the summer to hide my predicament when I got out of the car.

Also at school, even in the gymnasium, I had uncontrollable erections and was very scared that the teacher might ask me to come up to the greenboard.

The sex drive starts early. When I discussed, aged 35, with a girlfriend if it was possible to live without sex, I shocked her by saying that I had wanted sex for seven years without getting any. She didn't believe me until I added that it was when I was a boy. Like many others, I had had a couple of chances but was too drunk or the girl was too frightened.

Kindergarten bored me and I counted the days till I would start at the Lindebjerg school, a year earlier than usual being the youngest in class. I was very interested in my schoolwork and often raised my hand when the teacher asked questions. My replies were usually correct, which irritated some of the other boys who took to violence to manifest themselves. When the clock rang and there was free time in the schoolyard, I literally ran for my life, out of the school premises, to avoid being beaten up. There was a guard in the schoolyard, a teacher, but he didn't intervene when children were fighting. The 1950s were tough times.

It didn't cross my mind, neither then nor later, that, by being less energetic and less interested, I might have had a more peaceful life. But populism was never an issue. Getting things right was essential, no matter the consequences.

I never engaged in fist fights, but I did hit a guy once. I had learned to sail and one of the sailors harassed me constantly. I could not figure out why, and I had not given him any reason to haunt me. One day, when we stood on the beach and he harassed me yet again, I launched a jab on his jaw without warning. He began bleeding in his mouth and was so shocked that he didn't say or do anything. It worked. He never harassed me again.

I was very curious and questioned everything. Even as a child, I didn't trust authorities, which this incident illustrates:[16]

"You should take two vitamin pills every day, a green and a red one," my mother said. I was only about eight years old but asked,

"Why?"

"Because they are good for you."

"How do you know?"

"Because grandfather says so."

End of argument. My grandfather had a lot of authority on medical matters. When I studied medicine, I once asked him whether he had spared some textbooks I could compare with my own to see how much progress there had been in 50 years. His reply was stunning. He had donated all his books to younger students shortly after he qualified as a doctor. He didn't need them because he knew what was in them!

Surely, he was bright. So much, that he jumped a class at school and became a student only aged 17. I had great respect for him and his superb memory, but I was sceptical. How could he be so sure the pills were good for me? In addition, they tasted and smelled badly despite being sugar-coated. Opening the bottles felt like entering a pharmacy.

I dropped the pills, and my mother didn't try to force me to take them. But I was forced to eat what was being served. I hated the smell and taste of fried liver and therefore cut it in large pieces that I swallowed without chewing them. More than once, I came in trouble and got worried that I could get choked if they ended up in the windpipe.

And the vitamins? Vitamins are essential for our survival, so it must be good to eat vitamin pills to ensure we get enough of what we need to thrive, right? No. Biology is rarely simple. Our species has developed over millions of years, and we are very well adapted to our environment. If we eat a varied diet, we can expect to get adequate amounts of vitamins and other micronutrients. If some of our ancestors got too little of an essential vitamin, they

would have had less chance of reproducing their genes than people who needed less of the vitamin or absorbed it better.

We also need essential minerals, e.g. zinc and copper, to make our enzymes work. But if we ingest too much, we get intoxicated. Thus, given what we know about the human body, we cannot assume that vitamin pills and other supplements are healthy.

It is the earliest memory I have of a medical prophylactic intervention, and it took half a century before it became known whether vitamins are beneficial or harmful. Some of my employees did a review of the placebo-controlled trials that showed that antioxidants (beta-carotene, vitamin A and vitamin E) increase total mortality.[17]

All my childhood memories of drugs are negative. I suffered seriously from motion sickness and my grandfather gave me an antihistamine against it, which made me so drowsy and uncomfortable that I asked him to stop the car when I needed to vomit. The "cure" was worse than the disease and I refused to have any more of it.

Another memory illustrates how harmful and deceitful drug salespeople are.[18] When we went to Italy on vacation, my grandfather gave us Enterovioform (clioquinol) to be used if we got diarrhoea. What he didn't know and hadn't been told by the salesman from the Swiss company Ciba was that the drug only had a *possible* effect on diarrhoea caused by protozoans (amoebae and *Giardia*) and *Shigella* bacteria. Even that effect could be disputed, as no randomised trials had compared the drug with placebo. And it was highly unlikely we would get exposed to such organisms in Italy. Traveller's diarrhoea is almost always caused by bacteria other than *Shigella* or by viruses.

Ciba marketed clioquinol for amoebic dysentery and later pushed it worldwide for all forms of dysentery. The drug is neurotoxic and caused a disaster in Japan where 10,000 people developed subacute myelo-optic neuropathy (SMON).

Ciba, which later became Ciba-Geigy and Novartis, knew about the harms but concealed them for many years, and when challenged, they lied about what they knew. By 1981, Ciba-Geigy had paid out over $490 million to Japanese SMON victims, but the company didn't take the drug off the market until 1985, 15 years after the catastrophe struck.

The drug regulators should have acted but did nothing, which is pretty typical.

It is stressful to be a schoolteacher, and after some years, my mother came on disability pension. Børge was very ambitious, and my grandfather didn't like him. He told me that some people are so ambitious that they cannot say no to what other people find boring and therefore end up sitting on all types of foolish committees.

Because of his extra work, Børge was often travelling and used the opportunity to commit adultery repeatedly, which my mother found out. Being emotionally trapped, she started having depressions. My grandfather was convinced it was Børge's fault, and I think he was right. Being socially isolated with an unfaithful husband can easily drive people to depression. It was called "nerves," and my mother spent several periods at Dianalund Nerve Sanatorium where she recovered in a couple of months.

When Lea left home to study in Copenhagen, my mother and Børge got divorced, and he married his latest mistress. His bad manners continued. He gave his new wife everything he owned, which meant that when he died in 2007, aged 89, none of his four children inherited anything, which of course angered them. Even being dead, he harmed people.

When I became a teenager, I explored lots of things. I bought my first camera and became a member of sports clubs for football, basketball, table tennis and weightlifting. I became a

member of a radio amateur club and started building a sender. I was fascinated by it, partly because a man further down the road always knew how to repair my old radio.

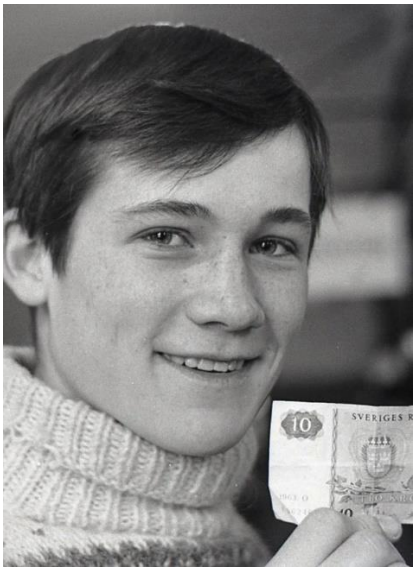
Once, when I worked with the radio myself, I got 220 V through me. As both hands cramped, I was unable to drop the radio for quite a while. Even today, I sometimes have nightmares that I am exposed to extremely high voltage from a power line and know that I am going to die.

I also did very stupid things. When I was 15 and visited the boat club in the winter with two friends, I told them that I would row over the canal and back on an ice flake. They didn't try to stop me, but a man came by who got very angry when he realised what I was doing. I thought that if the ice flake broke, I would just swim ashore. I didn't know that contact with ice water is very dangerous because you may hyperventilate, get cramps, and drown.

When I was 16, my class was on a history trip to Lund in Sweden and we had a little more than an hour left to ourselves. I strolled around in the streets with Tom Birkum Pedersen when he suddenly said, out of the blue, that he would bet that I could not succeed to kiss a girl before going back to Næstved. We got in contact with two girls, I did my best and got the address and phone numbers from the prettiest one, Marjorie Christel Johansson. I kissed her dearly when we said good-bye, which she enjoyed.

Tom became a musician for a living and he made mockery verses in the bus that the whole class sang on our way back about my conquest. I felt like an idiot. When Easter came, I visited her in Lund. My previous classmate, Bent Rostgaard Pedersen, and I had planned to hitch-hike to Stockholm, but it was bitterly cold, so we did not come further than Lund. I had hardly slept at all, lying directly on the ground in the tent without an air mattress. She later went to the final of a Miss Sweden contest and became the sweetheart of Ronnie Peterson, the best Swedish racer driver ever, who died at the Monza Circuit in 1978.

Christel



Peter

The following Easter, I hitch-hiked to Holland and Belgium where I had not been before. I was taken up by three Frenchmen in a Renault 2 CV – pronounced deux cheveau, two horses, but it had a little more horsepower than that - and we got along so well that I travelled with them for a couple of days and spoke French all the time. It was great fun. I so much wanted to be another person than the one who had had a difficult childhood with a

stepfather and grew up in a dull, little town that I felt as if I was French. Françoise Lidy visited me in my little tent one night, which made Paul jealous, and she screamed from inside the tent: “Tu crois que je veux coucher avec lui?” (Do you think I shall have sex with him?). I corresponded with Françoise for a while after my return.

Peter, Louis, Paul and Françoise

In the little road where we lived, three families had the same surname. I called the men green Sørensen, red Sørensen and multi-Sørensen according to the colour of the house they lived in and because the radio mechanic had so many children that he could barely feed them. They were so poor that once, when one of the children had birthday, the present was an orange, which the child had never seen before.

Young people are volatile, and it can be hard to choose an occupation. When I was 15, I left school to become a radio mechanic. But I changed my mind during our vacation in Italy. It was too late to change plans, but Børge was a member of the school commission and talked to the rector, which ensured I started at the gymnasium.

The only other time Børge helped me was when he allowed me to use his darkroom in the basement and showed me how to use his equipment so that I could produce my own black and white photos. I was very surprised about this kindness and even more so because I was clumsy, whereas Børge was very careful with everything. But I was a keen photographer and submitted a few photographs to competitions, which led to an award.

I now wanted to become a graduate electrical engineer and read a lot about how radios and other devices were constructed. But that interest didn’t last long either.

I was often out in nature to take photos, sometimes with my best friend, Egon Jensen, who succeeded to get a photo in *National Geographic*. I switched my interest to biology, which was a popular subject in the late 1960s. There weren’t many jobs other than becoming a schoolteacher, but I didn’t care. I became a student in 1968 when the traditions were broken, and everyone bubbled with optimism. We felt the world laid at our feet, and what was most important for me was to find a personal philosophy of life.

I was very interested in languages and read Sartre and Camus in French. I agreed with them that we should not follow routines, traditions, expectations, or other people's advice but should decide for ourselves.

But my favourite subject was mathematics. Once, our teacher gave us a problem he doubted any of us could solve. Something about predicting the number of fish a lake could sustain, based on the amount of nutrition, predators and other factors. I sat down an afternoon and solved the problem with three classmates, using highly advanced mathematics.

I changed my mind for the fourth time and now wanted to become a doctor, like my grandfather whom I adored and who was like a father to me.

I ended up taking both educations, becoming a biologist first. I spent many vacations with my grandparents, and during my final year at school, my grandfather invited me into his surgery, which was situated in Hellerup, a wealthy part of Copenhagen. This convinced me that I should not waste my life on being a doctor.

I noticed that many of the problems his patients presented with weren't anything to bother about but reflected boredom. Many women had very little to do, didn't have a job, and had servants. So why not pay the gentle and handsome doctor a visit, like in the joke about the three women who met regularly in the waiting room. One day, one was missing, and one of the others asked the third one what happened. "Oh," she said, "she couldn't come today as she is ill."

My grandfather told me that being a family doctor had its temptations. At a home visit, the woman suddenly said, "Kiss me, doctor." Which he didn't do. He remained faithful to his wife his whole life. Not only because this was the right thing to do but also because his marriage could be ruined if he brought a venereal disease back home. This happened to one of my colleagues who contracted gonorrhoea from a dentist's wife, which is not what you would expect. My piano tuner also visited many private homes and told me he was faithful to his wife according to his "capability."

My grandfather was only 17 when he met my grandmother, Anette Fibiger, who was 19. They became engaged and did not have sex before he had finished his education so that he could provide for her and they got married. He admitted it was very difficult to abstain from sex all these years. I think only religious people can invent the foolish idea of abstaining from sex before marriage, which the Bible dictates. When I moved to Copenhagen to study, my grandmother said: "Don't kiss all the girls." That was three years too late.

In 1967, a year before finishing school, one of my classmates suggested I participated in the annual school competition in athletics. I declined at first because I had never done any athletics apart from a few exercises in the gymnastics lessons.

It became very close. My worst competitor had practiced athletics for many years and later became the Danish champion in 3000 metres steeplechase. The emancipation in the late 1960s had the effect that youngsters sometimes walked around without shoes. I competed barefoot, also at the cinder track where I forgot to tighten the screws in the starting block. My foot went backwards when I started in the 100 metres race, and I got a poor time.

Other disciplines were 200 m, long jump, high jump, triple jump (which was very tough without shoes), javelin throw, discus throw and shot put, which came last. I was way behind my competitor before the shot put but in the last attempt of three, I suddenly shot the ball so far that he was convinced I had used the ball for girls, which was not the case.

I won the championship, which was the reason I decided to do athletics when I moved to Copenhagen to study biology. I became one of the pair who competed in 110 m hurdles and triple jump for my club, Frederiksberg Idrætsforening, and my companion, Flemming Lyng-

gaard Petersen, is still a close friend. He won the Danish championship in triple jump as a junior. I once did 200 m hurdles and won. The award was an ash tray - for an athlete!

I exercised very little, just had fun. I once started running with a guy from another club who became the Nordic champion in 400 m hurdles, but that lasted only one day. After we had run a lot in the morning, to the brink of total exhaustion, he declared that, after lunch, we would repeat it all in the afternoon. I love sports but am not that sort of guy.

I won the 4 x 400 m relay at the open Copenhagen championship with my club. I ran the third tour and was 10 m behind the front runner. To break him psychologically, I did not bypass him before the last curve. We led by 10-15 m before our last man. Their last runner was Sven-Erik Nielsen, the Danish champion on 800 m and record holder for 23 years. He thought it would be an easy win. But our man kept the distance. Sven-Erik was angry and asked who it was that ran so fast. It was the Israeli champion on 400 m hurdles who visited Denmark for the summer and trained with us, so we ensured he became a member before the competition. Sven-Erik tried to get us disqualified but we had followed the rules.

I participated in two decathlons, which closed the season in my club. It was amusing to see people do pole vault who never practiced it, and we didn't make more than about 3 metres. The worst part was the warming up the second day for the 110 m hurdles because the muscles were very stiff after a full day of competition. The finish, the 1500 m, was also tough because you are very tired when you have come this far.

The reason I was good at running and jumping was that I ran with morning newspapers before going to school to earn money for my photo equipment and for travelling. To save time, I ran the whole time when off the bicycle and jumped stairs in the residential compounds, as many steps as I could take at a time. I often wondered why no one ever opened the door and shouted at me when I didn't use the stairs at all but jumped down from one stair landing to the next. It made huge noise when I landed.

After the school championship, I hitch-hiked down through Europe. In Germany, a truck driver asked me if I wasn't afraid. No, I said, and showed him I had a knife in my belt, hidden under my sweater.

But that changed. In Northern France, I got a ride with a man who was going to Southern France, and we therefore needed an overnight's stay. He offered me dinner at a restaurant, and we drove on. A little later, he suggested we slept in the same hotel room. I said I preferred to sleep in my tent. When he asked if it was big enough for two, I replied, contrary to the truth, that it wasn't.

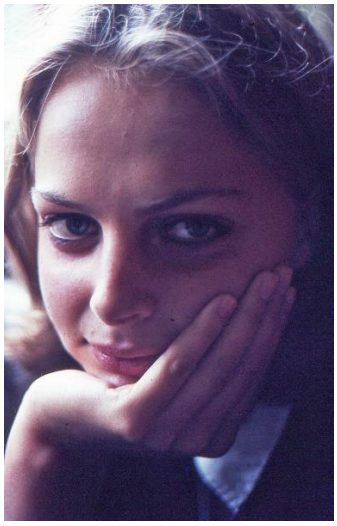
The atmosphere in the car became tense and I got worried. It became dark, and further ahead, the road went through a small forest. He slowed the car down, looking for a good place to stop, and now I got really scared. I discreetly unsheathed my knife and grabbed it, ready to use it if necessary.

Fortunately, car lights appeared in the distance, and he went on. Soon after, when we drove through a small town, I commanded him very brusquely to stop. I was ready to grab the car key so that the car would stop no matter how he reacted. Oddly enough he stopped, but I still had a firm grip on the dagger as I got out of the car.

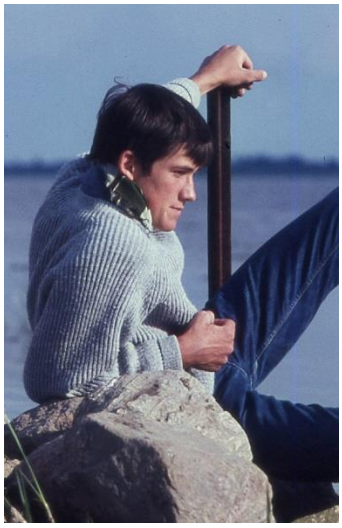
I had never met a homosexual before and had been too slow to realise the man was gay. The story shows how little it sometimes takes for an otherwise peaceful person to kill someone. I was strong, and if there had been a fight between us in the forest, I might, while just trying to defend myself, have ended up stabbing him to death by a wrong move.

My journey ended in El Prat de Llobregat, at a beach north of Barcelona. After that, there were endless hours of waiting for car rides before I came home.

Upon my return, I fell deeply in love for the first time in my life, aged 17. Hanne Brandt, who lived in Stockholm with her Danish parents, visited her two cousins in August who lived close to my home. One of them was my classmate, and we saw each other quite often. Hanne was the prettiest girl I had ever seen. She looked like a movie star, which was noticed by the other boys when we went to a party. They swarmed around her like flies, but I had made my first advances and was very happy that she chose me.



Hanne



Peter

When the autumn holidays came in October, I took the train to Stockholm and stayed in her parents' apartment for a week. Hanne and I desperately wanted to make love, but she didn't dare do it because her mother was very worried and paraded back and forth outside her door in the evenings when I was in Hanne's room where I was not allowed to sleep. Per-haps we should just have waited till her parents slept deeply but they could have woken up. Hanne was only 16 and had much respect for them.

I looked much forward to the Christmas holidays, but Hanne had fallen in love with another boy. I was devastated, stopped doing my homework and just let the months pass by, but I got good grades at the student exam anyway.

It took three years before I saw Hanne again, which was when I lived in Uppsala. I did not think about if we might renew our love affair, as so much had happened in the meantime. My interest in languages was so pronounced that I taught myself Spanish the last winter in school. After the exam, I hitch-hiked again, this time with Hanne's sister, Lene. In Annecy in Southern France, we split, as we did not get along too well. But after I had moved to Sweden, we became good friends and met several times the following years.

In Spain, I could make myself understood. At least to a degree. My rudimentary Spanish created a funny incident in Granada. I travelled with two Swedish boys and we went into town to look around. At every bar we passed by, there were only males, which was totally unheard of in the Nordic countries. So, in my poor Spanish, I tried to ask someone where the girls were: "¿Dónde está una casa con mujeres?" Oh yes, no problem, we were taken to a building where a big woman opened the window and said a lot very quickly. The only words I clearly understood were policía and razia. Oh dear. I only wanted to find a place that was not

full of men, and we were taken to a brothel! Spain was very catholic in 1968 and very backward under generalísimo Francisco Franco, which we didn't know.

We took the boat from Málaga to Tanger in Morocco where we stayed for a few days. I became so seasick on the return voyage that I understood why people in that condition are tempted to jump overboard to put an end to it. The boat ride took about five hours and, standing at the railing and trying to fix my gaze on the horizon to lessen the symptoms, someone vomited on me from the upper deck, which went into my eyes so that they hurt.

I must have eaten spoiled food in Morocco because my seasickness turned into diarrhoea when I came ashore. I had little money left and decided to go home as quickly as possible, as I was very sick. So, I took the train to Barcelona where I stayed at a youth hostel.

There was a Turk in the bed next to mine and when I tried to sleep, he attempted to caress me with his hand. I pushed it away, but he continued. I slapped his hand, but he continued. I had had enough of homosexuals by then, but I didn't dare beat him up because he might then attack me later, during my sleep where I would be defenceless. I lied down on the cold concrete floor and didn't get much sleep.

The next day, I was taken up by a young French couple. When we had passed the border, I asked them politely to turn off the radio, as I was disturbed by the very loud music. "What radio?", they asked. There wasn't a radio in the car, and they looked at me forbearingly, as it was easy to see that I was very unwell. I was so dehydrated that I hallucinated, the only time in my entire life. I distinctly heard a radio, but it was all in my head.

I was in such a bad shape that I cannot even remember how I succeeded to come home, but it was quite a feat. As I still had diarrhoea, I went to see my doctor who told me to feed on grated apples and water for a whole week. This foolish advice was impossible to live up to. I dropped the advice and slowly recovered while eating and drinking what I pleased.


Lise


Peer


Bodil

In September 1968, I enrolled at the University of Copenhagen to study biology and rented a room in a house owned by the widow of a judge, Bodil Richter, at Peter Bangsvej 275. She was outstanding. She enjoyed having young people around her, and her house quickly became a kind of Forum Romanum for all sorts of eloquent philosophical, scientific, and political discussions.

Through a friend, I met with two psychology students, Peer Nielsen and Lise Stanley Johansen, in November 1968 and Lise and I immediately fell in love. Bodil had told me she

would not tolerate girls in my room. But she had a big heart. Lise slept in my tiny bed, and Bodil was happy, as she loved Lise, too.

Two months later, we went on a skiing holiday in Norway where we stayed in a remote hut with no heating. As the heat from the firewood didn't last all night, it was bitterly cold in the morning with ice on the inside of the windows.

After half a year, we wanted to share an apartment but there was a serious shortage of them. The only option was to buy one but there was no free market for the cheapest ones, which students could afford if they worked alongside the studies. And the buyers would need to become approved by the chairman of the apartment association in the building.

This was my first experience with corruption. The chairman refused to approve the deal unless we got married. We had no such intentions, but to get the apartment, we married pro forma, aged only 19. There was no celebration, just a signature at the town hall. I didn't even invite my parents to the dinner Lise's parents arranged in their house afterwards.

The pro forma arrangement angered me because, being an existentialist, I abhorred the idea that others should make decisions on my behalf.

But the forced marriage was the minor part of the deal. The chairman demanded a huge sum, corresponding to a teacher's salary for four months, "under the table" as we call it in Denmark when no one is supposed to know it ever happened. My grandfather paid for me. He was very worried that my difficult childhood would at some point break me, so he supported me generously, both emotionally and financially.

During the last two years at school, I took piano lessons, and when I moved to Copenhagen to study, my grandfather gave me a brand-new Yamaha piano and also a new scooter. Like other pupils, I played classic pieces, but one day I asked if I could play jazz and learned to play St. Louis Blues. Later in life, I played a little of Scott Joplin and Duke Ellington. I loved it, but my talent was limited and I could not improvise.

Half a century later, nine people with a remarkable career were interviewed by a newspaper in the series, *How did I become so wise?*[19] I said that talent is something you are born with, not something you can acquire, which is why it matters to find something you're good at and enjoy doing.

I noted that what had marked a turning point in my education was when I read novels by Sartre and Camus. I decided to choose myself and be true to myself, regardless of what others said. I have inherited Danish philosopher Søren Kierkegaard's collected works from my grandfather, who inherited them from his father, who had them bound in leather when he lived in Madras. When I started reading Kierkegaard, I realised he was much wiser than the two Frenchmen. He said that if you don't choose yourself, you don't choose life.

My advice to young people was that they should be faithful to their ideas and ideals. It is much more interesting to take different paths than others, and you will often find things others overlook. Dig deep if you become a researcher as this is where the skeletons are buried. And don't be put off by all the howling and screaming that comes from those who have buried the skeletons in the belief no one would ever find them. Doubt everything. And don't believe in anything for which there is no evidence.

I am romantic, full of dreams and easily moved, like my mother was. My upbringing, with the constant lack of love from my stepfather, meant I was a confused young man who had not yet found myself when I left school but with a huge appetite for life.

I was restless and adventurous, with no fixed goals. I wanted to explore the world, and after having known Lise for a year, it slowly dawned on me that I had found the love of my life much too early. But as I did not want to hurt and disappoint her, I found myself stuck. If I stayed, it would be wrong, and if left her, it would also be wrong. It was almost like in Kierkegaard's writings: Marry, or don't marry, and you will regret both.

I felt very badly about this, and one evening, when we visited one of Lise's friends, it became unbearable. I went to the toilet in order not to draw attention to my struggles deep inside and stayed there for quite some time while contemplating the situation. When I came out, I told the girls that I wasn't well, which was true.

I am not the type that can become depressed. I am a fighter and never give up. But should I one day end up in an unbearable situation that cannot be remedied, I would reason - being an existentialist - that if life has nothing to offer, it is time to stop it.

Perhaps Socrates reasoned the same way when he declined offers of helping him escape from prison when he had received a death sentence in Athens for asking questions. We should ask questions all the time, particularly addressing our authorities who often get matters wrong and try to hide their mistakes to save face. This is why I have chosen Socrates as the front image for my Institute for Scientific Freedom, which I established in 2019.[20]

In 1970, when spring came, I couldn't help looking at the young women, lightly dressed and attractive, feeling it was far too early for me to have settled down. My life had hardly begun but seemed like it had already been laid out *for* me and not *by* me.

When it became clear to Lise that the relationship wouldn't last, she said one day: "Do you really think women are hanging on the trees?" Well, I was a warm-blooded young man who had been popular with the girls, so, shamefully, I thought to myself that maybe they just waited to be picked like ripe fruit, and if that was not the case, less would do.

I wasn't ready to have the same woman for the rest of my life. Some people are, and some aren't. I see it as a biological phenomenon, hard to escape from. In nature, dominant males spread their genes as much as possible, which carries an evolutionary advantage, so perhaps I am dominant. At the very least, I am not a weakling.

The next lodger at Bodil's house was psychology student Bo Fisher Nielsen who took over not only my room but also Lise. A group of young people, all related to Bodil's inner circle, went on summer holiday at Vejers' beach in Jylland the same summer that Lise and I broke up. Lise was devastated but she and Bo became lovers, and they are still together. Bo did not hold any grudges. He helped me move my furniture to Uppsala in Sweden in a rented car in August, and all three of us have continued to meet, as we belonged to the friendship circle that started when I moved in at Bodil's house.

I finished the bachelor of my studies, which included zoology and botany as main subjects, and nuclear and mechanical physics, chemistry and mathematics as minor subjects.

Since I was so restless, I wanted to continue my studies elsewhere and I narrowed down the options to Uppsala and Montpellier in Southern France.

I regretted I did not choose Montpellier. Instead of speaking fluent French, I speak Swedish fluently, which is less useful.

**Three years in Sweden**

In June 1970, I needed to finish my studies in Copenhagen by attending a two-weeks course in marine biology in Frederikshavn. Most days, we went out on a fishing boat in the morning

and studied the catches in the laboratory in the afternoon. But I became so see-sick the first day that I stayed in the lab for the rest of the time.

One evening, I met three Swedish girls in town who were on vacation. I took an interest in one of them, Eva Söderkvist from Örebro, who responded positively. It was my great luck that Eva was also going to study in Uppsala after the holidays, as I had seriously underestimated the emotional turmoil that befalls those who leave their country to establish a new life elsewhere.

I came to Uppsala before Eva arrived and felt extremely lonely. I sat in my student room and looked at my furniture and the empty walls and thought: Why on earth did I come here, far away from friends and family? I hadn't realised how important social relationships are for human beings before I didn't have any. I was used to having a lot of good company.

The easy going and optimistic fellow suddenly found himself in alien territory. A sense of meaninglessness and extreme anxiety - totally strange, new feelings - crept onto me. This was shocking, and it was an immense relief when Eva arrived.

We had a really good time together but were very different. I thought a lot about everything, was philosophical and wanted to change what wasn't right whereas Eva enjoyed life as it was. We were together for only three months before we split but continued to be friends and stayed in contact. Eva even came for a visit after I had moved back to Copenhagen.

I studied zoology, botany, physics, and genetics in Carl von Linné's hometown, and I finished my studies by specialising in insects. I wrote a 28-page report about a family of prey bugs, the Nabidae,[21] and was reproached by my examiner for not having written it in perfect Swedish, which annoyed me. I did my best and spoke the language so well that people took me for a Swede from Norrland.

The bugs I studied belong to the order Hemiptera (half-wings, so called because the outer pair of wings are membranous at the ends, in contrast to beetles). They include bed bugs and tropical species that suck blood from humans and spread Chagas disease, also known as American sleeping sickness.

It lessened my emotional pain that there were five other students in the corridor and a communal kitchen where we sometimes dined together.

It was difficult to make new friends. Swedes are a little more distant than Danes and call us the Italians of the North because we are more easy-going. A Danish journalist who had lived in both countries wrote a book about the differences that was not well received in Sweden. He joked that, in Sweden, we have a problem; it is not serious but there is reason to worry. In Denmark, we have a problem; it is serious, but there is no reason to worry.

In 2001, at a congress on peer review in Barcelona, the editor of the Norwegian medical journal, Magne Nylenna, told a joke about the national differences while we enjoyed our champaign at the welcome reception. "In Sweden," he said, "everything is forbidden unless it is specifically allowed." "In Norway, everything is allowed unless it is specifically forbidden." Well, I thought, that doesn't leave any option for Denmark but oh yes: "In Denmark, everything is allowed!" We all laughed, including the Swede in our company.

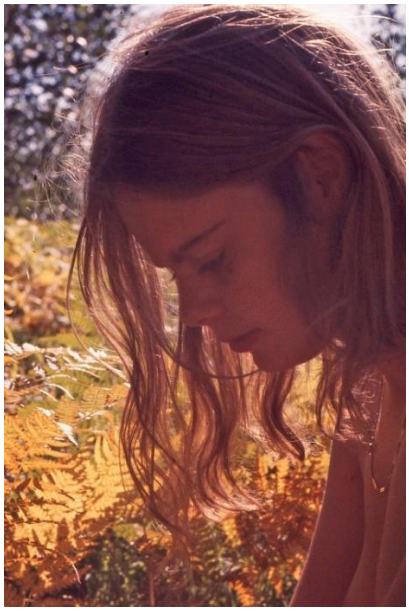
In Denmark, we talk about "Prohibition-Sweden." Once, in a swimming hall, I saw a poster with ten things that were forbidden. This struck me. Okay, but what about stating what is allowed, for a change?

In contrast to Denmark, you can only buy liquor in certain stores owned by the government, "Systembolaget." The Swedish politicians thought their countrymen drank too much beer, so they decided that ordinary beers, with only 3.6% alcohol, should no longer be sold in stores but only in "The system," as the alcohol stores were nicknamed. This led to a great

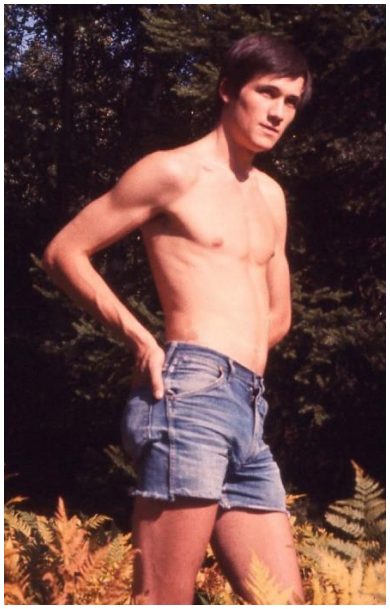
cartoon in a Danish newspaper. A customer said: “I only intended to buy a few beers, but now that I am here, I might as well get a whiskey and a vodka, too.”

When we went out for a dance in town, the standard was that each of us drank the most of a bottle of Parador red wine in our kitchen, which only cost 5 crowns. We were rarely entirely sober. As one said: Swedish youth can have fun without alcohol but why run the risk?

I got a new girlfriend, Anette Peterson from Katrineholm. This relationship lasted five months, but we stayed in contact for many years and visited each other.



Eva



Peter

Anette

Despite being analytic in everything else I did, I was very naïve when it came to women. They meant a lot to me, and, like my other girlfriends, Anette was very pretty. My grandfather once said that because a girl is pretty on the outside, it doesn’t necessarily mean that she is also pretty on the inside. But my eternal optimism made me think every time that I could make it work.

One evening, the temperature had dropped from around freezing point to -18$^0$ C before I drove home from Anette’s student room on my scooter, without gloves. She suggested I sold it and bought a used car instead, which I did, a Renault Dauphine. When it turned out it was too rusty to pass the car inspection, I bought a car that wasn’t rusty, but with a very bad motor. Helped by a student in the corridor, I exchanged one motor for the other. We were strong and lifted the motors with our bare hands at a gas station.

I got some friends along the way, but only one that reminded me of my old pals in Copenhagen. Anders Tidström was a philosophically inclined soulmate from Gävle who shared many of my views. We often discussed how we should best manoeuvre in a world that was crazy in many ways. Fifty years later, I found out where Anders lived, back in Gävle, and we got in contact again.

In the summer of 1972, I went south in my composite car with my friend, Peer Nielsen. Already in Germany, it made trouble, which a mechanic fixed. When he heard we were bachelors, he lamented that he was married and couldn’t go on any adventures.

In Basel, we filled the car with fuel, but it wouldn't start. The moving parts were stuck. A mechanic looked at the car and said he had a solution for us. This cheered us up until he added: "Buy a box of matches, pour gasoline over the car, and set it on fire!"

We rolled the car out of the gasoline station and parked it in the grass nearby, along the road, without locking it. We took a taxi to the nearest train station and sent most of our luggage home and continued our journey to Northern Spain hitch-hiking.

Two months later, I got a letter from the police in Stockholm that had been contacted by Interpol. The police in Basel wanted to remove the car and their fee so far amounted to 60 Swiss Francs. I replied that the car had brand new tyres, and that the police could sell it and keep the difference. The Swiss police replied that, "Eine Verwertung des Wagens in der Schweiz kommt, da völlig wertlos, nicht in Frage" (A reuse of the car in Switzerland is not an option because it is totally worthless). They also wrote that if I didn't reply before a certain date, they would scrap the car. Fine with me. I didn't hear from them again.

As I still didn't know what to do with my life, I turned to chemistry after the insects, which would allow me to teach in biology and chemistry. I wasn't interested in this but saw it as an insurance, something to fall back upon, if nothing better turned up. I was home-sick but didn't want to go back to Denmark before I had a full Swedish university degree.

Then, just as the new semester had begun, the teacher said that a chemistry student in Lund in Southern Sweden wanted to study chemistry in Uppsala, and he enquired if anyone would be interested in an exchange. I was very relieved and went to Lund where I settled in an apartment I shared with three other students, which was ideal. There were always people around and Lund was close to Copenhagen. No more feelings of loneliness.

I am inquisitive and don't take anything for granted. Whenever I can, I want to investigate things for myself. In addition, I am aware of human imperfection. On the first day in the chemistry lab, the teacher showed the new students around and emphasised security greatly. He said that, in case any of us got a corrosive or toxic liquid on the skin, there was a shower in every room, and he pointed his finger at one of them. I asked him to demonstrate that it worked. He became annoyed and tried to avoid testing it, saying it was just a shower and of course it worked.

I don't give up easily and persisted. The teacher became sour but pulled the handle. Drip, drip, drip. One drop at a time was slowly released from the shower. My insistence led to all showers in the whole institution being renovated, removing the calcium carbonate that had blocked the outlets during many years of inactivity. No one had ever tested that the showers worked. Since people often make errors, I was vehemently against introducing nuclear plants in Denmark, and we still don't have any. I was convinced that, no matter how many safety procedures that were applied, it would go wrong one day, which it did 14 years later, in Chernobyl in Ukraine.

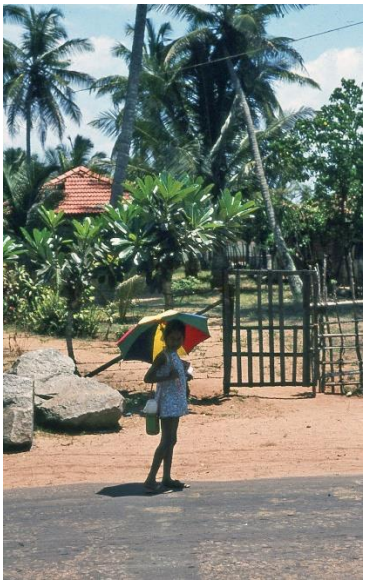
**Sri Lanka**

In March 1973, I saw an ad in a newspaper for a two-week charter trip to Sri Lanka for only 1200 crowns. This was my first trip to the tropics and it was very primitive. There were no mosquito nets and no windows in the rooms, only rectangular holes. Huge spiders crawled around on the walls of the hotel, and spiders, scorpions and Cobra snakes, of which there were plenty in the gardens, could come in while we were sleeping. Many of us didn't sleep too well the first few nights.

We were two people in each room and my companion was an American who was afraid that the fan in the ceiling might fall down and hurt him during his sleep, so he demanded that we put it off. The nightly heat, with no fan and no air condition, was devastating.

But the trip was exciting. One day, we went on a tour to see crocodiles in a big lake. There were hundreds of them, but we didn't see a single one; they were all submerged. Later the same day, I looked for insects in the bushes in a wet area when I suddenly spotted a crocodile ten metres away. Luckily for me, we ran in opposite directions.

Rice field



Outside our hotel

Fishermen

In the jungle, I cut my arm with my army knife, a bayonet from World War II that I got from my grandfather, and it started bleeding. The guide found a special plant, broke off a leaf and pressed juice into the wound, which stopped the bleeding immediately. When I had returned to the hotel, I noticed that my legs were full of leeches that were having a great party on me. Their triangular mouthpieces are so sharp that you don't feel anything when they cut into you.

In the mountains, we stayed at a former colonial hotel. There were so many insects at night that they covered the ceilings almost entirely. We saw fireflies (which are not flies but beetles) and flying foxes were hanging in the telephone wires and trees everywhere.

The restaurant wanted to cook an English meal for us, but the two Swedes I travelled with and I said we wanted local food, and I ordered a pepper steak. It was so hot that I could hardly eat it, and drinking beer only made the pain worse. It was like having a fire on the inside. When the waiters came back and asked what we thought about the meal and I told them so, one of them said: "But we didn't put as much pepper in as we usually do!"

When I came to Sri Lanka again 40 years later with my family, there were far fewer animals. I wondered where all the big spiders and the flying foxes had gone.

**The Finnish connection**

In June 1973, only two weeks before I moved back to Copenhagen, I went on a dance at a student place in Lund. I met a Finnish girl, Sirkka-Liisa Luostarinen, who came from central Finland but had emigrated to Sweden for her studies and had learned Swedish fluently.

It was not particularly smart of me to meet an attractive girl so close to going home and it came with a price.

We were a very good fit, the first one since I left Lise. When I told my uncle about her, I joked and said that at first, I had Lise, and now, I had circa Lise. My uncle, a very witty person, replied: ''So, what does she call you then?"

I went to Finland in July to visit Sirkka-Liisa and her parents in Varkaus. On the boat from Stockholm to Helsinki, I met three young men from Portugal who looked forward to their adventures in Finland. When they heard, I was going to see my sweetheart, one of them exclaimed: "Minä rakastan sinua!" When I looked bewildered at them, they laughed and said it means "I love you!" They were well prepared whereas I had not learned the basics.

With my keen interest in languages, I started learning Finnish but quickly gave up. It is a very difficult language. But I can still startle Finnish people with the little Finnish I remember like kaupunginkirjasto (city library) and rautakauppa (hardware store).

Sirkka-Liisa's parents had two summer houses in the wilderness. She lent her father's car and we spent a whole month out there. I was very impressed by her father, and by Finns in general. Finland was attacked by Russia on 30 November 1939 and the Finns, including Sirkka-Liisa's father, fought very bravely against a much stronger enemy.

The summer was unusually hot. At times, the temperature was higher than in Athens. Central Finland is full of lakes and both summer houses were a few metres from a lake, which was ideal for fishing and swimming.

It was one of the best months of my life. I continued my studies of Nabis bugs, of which there were plenty in the grass. I brought an aquarium to Finland which I used as a laboratory, introducing various insects that preyed on each other. I made detailed notes in a notebook over 46 pages, which I have spared. Fifty years later, when I read them again, I regretted that I did not publish any of my observations.

In the forest, I found out that a particular spider was not afraid of the various Nabis species but one, which looked like an ant and moved like an ant. This caused the spider to run away whereas it attacked boldly all other Nabis species. It is called mimicry when an animal gains a survival advantage by mimicking another species.

I also found out that, even though insects do not have many nerve cells, only about 0.002% of the number in rodents, they have enough to make them very different, just like humans are very different. Even their temperaments are very different.

Some bugs from the same species were shy and others were bold; some dropped from a grass leave to the floor when they encountered an enemy while others didn't budge. I realised why biologists assign names to the animals they study, as it makes the research much easier. I named a totally fearless bug Long John Silver after the one-legged pirate in one of Robert Louis Stevenson's novels because it was so fearless that it had lost one of its legs. What they all had in common was that they copulated surprisingly often.

**Scary experiences in Tunesia**

In September 1973, Sirkka-Liisa and I went on vacation in Tunesia for two weeks. This turned out to be a highly dramatic experience. I have preserved a 17-page diary from the trip where I wrote: "It is worth recording this before it fades from memory; it serves as a dire warning for coming visitors to Tunesia."

We were unprepared for the hostility and shrewdness we were met with. We naïvely thought that travelling in North Africa was like travelling in Europe, and we were kind to

people who were kind to us without speculating if there was an ulterior motive behind the apparent kindness.

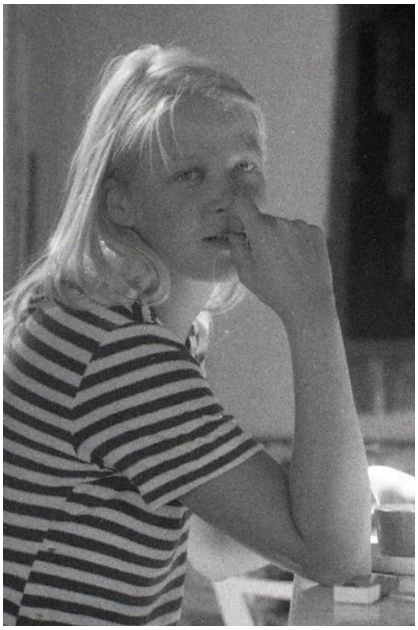
In Sousse, we were approached by a very friendly Arab who asked if he could sit at our table. When he said it could be interesting for us to see an Arab home, we followed him into the souk.

The streets, which were already narrow, became narrower and narrower, and I started feeling uncomfortable. Being naïve doesn't mean you have no common sense and don't observe what is going on. After a long while, the Arab pointed at something that looked more like a small hut than a house and said that this was where he lived. He opened the door, and it was totally dark inside. Sirkka-Liisa wanted to step in, but I held her back. Noting my hesitancy, the Arab called out for someone, and a woman appeared in the doorway whom he presented as his wife.

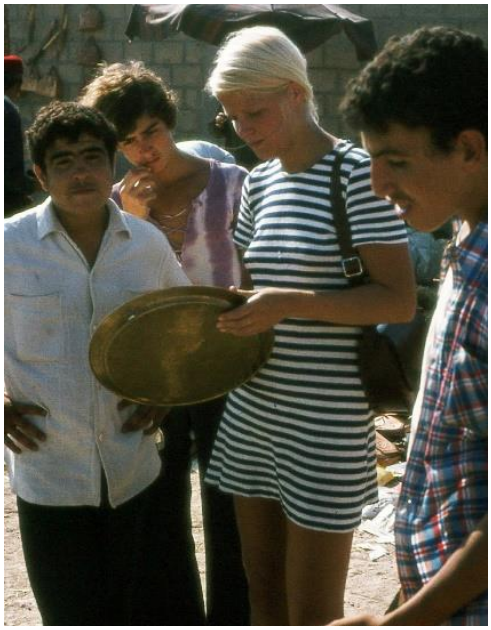
In contrast to all the other women we had seen, she wore heavy makeup. She looked like a prostitute.

I turned around and took Sirkka-Liisa with me. She was upset about my manners because the Arab had been so kind to us. I said that if we had gone into that hut, she might never have come back to Europe again but might have ended up in a brothel or a harem after the Arab had knocked me down and perhaps even killed me. She would have been a huge attraction, beautiful as she was, and with blond hair.

We didn't know that a girl should not walk around in Tunesia in small shorts or a dress that showed her legs. Most Tunesian women were rather mummified in their long dresses that didn't reveal anything and they even covered their hair, which, curiously, the men don't do. Hair is only sexy on women, it seems. I will never know if I was right in being suspicious, but I did the right thing in the situation.



Sirkka-Liisa in Finland



Sirkka-Liisa in Tunesia

We laid the experience behind us and decided to go as near to Sahara as possible. We went to the train station where many people were waiting at the platform. When the train arrived, the youngest and strongest pushed old and handicapped people aside and boarded the train before them. This was not British queue culture but survival of the fittest.

The train ride took ten hours, including a change of train in Sfax. The train was over-crowded and even in first class, one had to fight for a seat. The first time the train stopped, it was invaded by thousands of flies.

Fifty kilometres before the end station in Tozeur, everyone left the train to board buses apart from us who were now alone. We sat in total darkness, in the middle of the night, because the lights on the train didn't work or were not turned on.

There were no taxis in Tozeur, so we walked around till we found what looked like a good hotel and got a room. But it had stinking toilets, common for all the rooms.

People didn't like us. The waiter who served the food was very condescending, and the next day, we experienced more of Tunesian "hospitality." We asked for a taxi to drive us into the desert, but it cost 2.5 times more than in Sousse per kilometre. There were several taxi drivers, and they became very irritated when we said this. One claimed that the tyres were double as expensive as in France. If so, then why didn't he buy his tyres in Sousse? Or why was a taxi ride much cheaper in Sousse? Another driver said that the gasoline cost was high and gave a price that turned out to be 13 times as much as the correct one.

There were monstrous lies all the time. We felt we had landed on another planet. The local bank offered much more reliable information than the tourist office, which was likely complicit with the taxi drivers and shared the revenue from the fraud scheme.

We continued our search for an honest person and settled for a driver we felt could be trusted. He was not aggressive like the others, but he was smarter. We agreed on the price and the number of kilometres to an oasis we wanted to see, but upon our return, he claimed he had driven us over double as far as what we had agreed and demanded a huge sum of money.

We had already learned that we couldn't trust anyone in Tunesia. We had therefore made a note of the kilometre count before the journey started, which the driver had seen us doing, and now he showed us a count that couldn't possibly be true. We later found out that he was a mechanic, so he knew how run the counter forward when the car wasn't moving, but there was nothing we could do but pay him what he requested.

After a week in inner Tunesia with an endless row of "fantastic lies," as I called them in my diary, on top of all kinds of tricks from everybody - businessmen, children, hotel staff, and in particular the Bedouins - hostilities, peeing in the bus, using the curtain in the bus as a handkerchief for the common cold, attempts at doubling the price or worse for everything, and uninhibited staring for several minutes at Sirkka-Liisa's bare legs, we had only one thing on our mind: To end the nightmare by going back to Sousse as quickly as possible.

We took the bus to Gafsa and waited for the night train to Sousse to arrive. This was the only available train connection.

A young man turned up and offered to show us where the Bedouins lived. I spoke French well and explained that we weren't interested and that everybody offered their "help," which meant trying to cheat us and get some of our money in all thinkable ways, which we abhorred. However, we were still too kind to people who approached us. I foolishly said he was welcome to join us if he was going the same way.

He explained that the Bedouins were poor and robbed people, but as he was nicely dressed, we thought it would be safe to follow him.

To our great surprise, as he had warned us against robbery, we suddenly found ourselves in the middle of a Bedouin camp, situated at a garbage dump. A woman approached us, with a child on one arm and an outstretched hand begging for money. "This is my mother," said

the Arab. We didn't give her any money but became very nervous. The Bedouins stared at us, and their looks were not friendly.

As the camp was isolated, we started walking fast and determinedly, to get out to the road as quickly as possible. We discussed what we should do if we were attacked. The Arab got angry and told us to use a language he could understand. He asked for my address and became even more angry when he didn't get it.

Five kids followed us, and I held firmly on to my tripod used for taking photos with my tele lenses, ready to defend us. We crossed a wadi - a dried-out river bottom - and the Arab now said he wanted to escort us across another desolate area to get to the train station.

We refused, changed direction, and spotted other people half a kilometre away. The Arab asked for money for his brother, but we declined once more. His tactic was to scare us so that we would be happy to pay whatever he requested just to get away safely.

We arrived at a restaurant and ordered tea and coffee to calm down a bit, but the Arabs stared hatefully at us. It went from bad to worse when a man with a highly scary look whom we had noticed earlier in the day sat down and gazed at us. It was like being involuntary stand-ins in a horror movie.

We rose and asked the waiter if the bus to the train station stopped at the restaurant. It did, but as the bus didn't arrive as planned, we walked back to the city centre to take it from there. When the bus stopped at the restaurant, the creepy guy came on board. I looked at him during the three-kilometre ride to the train station and speculated if he had sinister plans for us.

The bus stopped 300 metres before the train station, which was very isolated. It was dark, and there were only two people in the waiting room apart from the scary guy. It was highly suspicious that he had followed us to the station, as it took another 4.5 hours before the train left at midnight, and as there was a bus every 30 minutes.

Sirkka-Liisa remarked that he must be a criminal. Sure. He had a huge scar across his cheek of the type you see in crosswords, which suggested he had been involved in a knife fight. And, in contrast to all other Arabs, he wore a jacket over his shirt, which covered the upper part of his trousers. This was strange because it was very hot. I was convinced that we were facing a criminal who had planned to attack us during the train ride with a knife, hidden under his jacket, in total darkness.

The Arab asked various questions, the whole time with a spooky smile on his face. We told him we were going to Sousse and asked where he was going. "To Sfax," he replied. And why? No reply. "Do you live there?" Silence. He finally said he lived in Gafsa, and when asked again what his purpose was with going to Sfax, he replied: "Nothing special. I just want to look around."

It was a highly precarious situation. We expected something very bad was about to happen. And perhaps he even had accomplices who would also board the train.

I played a lot of poker at the gymnasium, and I decided to try to bluff the Arab. I would show to him I wasn't afraid and was also armed. I took out the large bayonet from my rucksack that I always carried with me when travelling and fastened it to my belt.

We decided to rescue ourselves by walking back to town but as soon as we rose, the Arab became suspicious and asked what we were doing. I said that there was still plenty of time before the train arrived and that we needed some fresh air. It was equally warm outside as inside, but the Arab accepted the explanation.

There were a few houses by the station, and I considered knocking on one of the doors to ask for help because we were in great danger. I quickly dismissed the idea because so

many people had stared at us with blind hatred in their eyes. I therefore feared that the inhabitants would hand us over to the criminal if we asked for help.

I looked back over my shoulder. The Arab didn't follow us, so he must have remained in the waiting room.

When out of sight, we ran as fast as we could the three kilometres to the bus station. There were two men there and, to our great relief, one of them spoke Swedish because he had worked in Sweden and now lived in Gafsa with his Swedish wife. We did not want to run any risk by staying there, so we took the bus back to Gafsa.

Back in town we met a French couple whom we embraced to relieve the panic we had just endured. They told us there was another possibility for going back to Sousse, a bus that left very early in the morning. We found a hotel for the night. As we did not want to use the filthy common toilets, Sirkka-Liisa peed in the sink. When I turned off the light, I got a powerful electric shock. Having been in grave danger, it was very difficult to sleep. I woke up many times and kept the bayonet by the bed after having checked if it was possible for people to attack us by coming in through the window. Given our experiences, I was now overcautious and very anxious, too.

We asked the night watchman to wake us up at 4 in the morning so that we could take the bus to Sfax. He didn't. He didn't even have an alarm clock at his side when we found him sleeping. Luckily, there was another bus we could take. We stayed in Sousse for the rest of the holiday, and I decided never to go back to Tunesia again. My naivety was gone forever.

**Back in Copenhagen**

When I left Lund, I hired a room in a big apartment at Sankt Knuds Vej 31 in Frederiksberg that I shared with three friends. I wanted to get a full university degree also in Denmark and worked on a special subject the next year about how water bugs get enough oxygen to survive when submerged.[22]

Sirkka-Liisa and I went back and forth between Lund and Copenhagen, by train, boat and bus. Under other circumstances, it is unlikely we would ever have split, but she had already changed country and culture once and was not keen to do it again by moving to Denmark, and I did not want to go back Sweden. My Swedish adventure had the effect that I realised how much I appreciated my life in Denmark.

Sirkka-Liisa ended our relationship after five months, which made me very sad. We loved each other deeply, so it wasn't easy for any of us to quit. She got a new boyfriend after a while, but it didn't last, and six years later, she contacted me again. I visited her in Norrköping where she worked as a teacher on my way to Södertälje to attend a course. We were together again during the brief visit but Sirkka-Liisa had a difficult time in her life, which was why she contacted me, whereas I had a good life, apart from being single.

This was the last time I saw her, but we stayed in contact, which brought back all the good memories. This is how I am. My personal history is important, and it means a lot to me to preserve old friendships. A love affair is the closest friendship you can get, and true love never dies. There will always be some of it left.

Sometimes a bit too much of it is still there. Two of my Swedish girlfriends visited me after they had entered a stable and long-lasting partnership with another man. I was surprised when they wanted more of me than just saying hello. Being unfaithful with an earlier lover is beyond my moral principles, but I was single and appreciated their visits. Their adultery was not my problem. It continued till 1987.

In the summer of 1974, aged 24, I found myself in a difficult situation. I had two university degrees and could find work both in Sweden and in Denmark, but I had no idea about what I wanted to do. The autumn developed into the biggest crisis in my life.

I browsed job advertisements in my newspaper and saw that the Danish travel king Simon Spies was looking for a private driver. I drove a lot even though I had no car. To earn money for my studies, I had been a taxi driver in Copenhagen, which was very convenient because I could decide when I wanted to work.

As there would be many applicants, I needed to make a difference. I went to Spies' headquarters and said I wanted to deliver my application personally. That wasn't possible. As I don't take no for an answer, I insisted. The receptionist got annoyed, took the phone and called Spies, who, to her surprise, asked the stubborn young man to come up and see him.

Spies resided in an enormous office, the size of half a handball court. He had two educations, one as a lawyer and one as a psychologist, and he asked what I wanted to do with mine. I said I wanted to become a gymnasium teacher. "Oh, but that is also interesting," he said in a tone that left no doubt that he found it very boring. After half an hour, without knowing anything about the other applicants, he offered me the job and asked me to consider it. He also suggested I could analyse his food chemically because he suffered from diabetes and other ailments.

I declined both job offers the next day. It reflected my undecidedness and adventurous spirit that I applied for the job, as I didn't really want to work for him. It was widely known that Spies abused women. Much later, it was revealed that he had an even darker side. Once, he paid a young woman 10,000 crowns for having someone break her arm.

My chances of getting an interesting job were small, as I had not done any research during my studies and had not taken other initiatives that would make employers more interested in me than in countless others. I got very high marks at my exams, but, contrary to what I had expected, that did not appear to be important.

What most people did in my situation was to become a schoolteacher. I tried, at Falkonergårdens Gymnasium, but it didn't work out. When I enrolled in the gymnasium nine years earlier, I wrote on my school bag: "Three years in the quarry." I had barely left school before I was back again, now on the other side of the teacher's desk. I wasn't much older than my pupils and felt I belonged more to their group than to my new tribe of teachers who, moreover, smoked to an unbelievable extent, which I had to endure in the staff room.

I wasn't mature enough for such a job and had difficulty accepting that this was what I was going to do, for more than forty years. Life seemed to be over before it had started, just like I felt before I broke up with Lise four years earlier and moved to Sweden. I was a rolling stone and saw life as an adventure, a journey.

Two things annoyed me greatly during the six months where I tried to learn how to teach, supervised by a teacher. In biology, we didn't use textbooks much, although wonderful textbooks were available. This was in the dark 1970s when the universities and academic life were heavily influenced by dogma, particularly Marxism, and it wasn't well received if you raised too many questions that things could perhaps be done differently.

My supervisor required of me that, instead of using textbooks, I should produce the educational material myself, as it needed to be relevant for the time we were living in. Some have aptly called these years the history-free period. I found myself cutting newspaper articles about the oil industry and pollution and I spent countless hours at the photocopying machine putting my "breaking news" compendia together. I asked myself: Why this restless

emphasis on something that happened yesterday, considering that my subject is biology, which goes back billions of years? It was totally off target.

The other issue was the prevailing fashion in pedagogy, which dictated that the teachers needed to write down a detailed plan before each lecture outlining what learning goals they wanted to achieve, subgoals at that, how to achieve them, etc. After each lecture, we were expected to analyse our performance and discuss with our supervisors whether we had achieved all these goals.

Thinking through what you wish to achieve beforehand and evaluating it afterwards is reasonable, but there was so much of it that it totally drained me. I am not the bookkeeping type but had not yet fully realised that I am a pioneer who constantly wants to change things for the better and to break new ground. I didn't belong there.

I also lectured in chemistry, and particularly in that subject, the rigid template felt like overkill. To teach people how chemical substances interact is straightforward. There are some facts and principles you need to learn, like in mathematics, and if you don't want to learn them, or cannot learn them, detailed bookkeeping won't help.

Imagine if a piano teacher was expected to construct similarly elaborate schemes before every music lesson she gave and to evaluate herself afterwards. She would quickly find something more meaningful to do.

The séances with my supervisors reminded me of the Danish lessons at the gymnasium where we were asked to interpret poems. I was quite bad at this type of guesswork and was irritated that the authors hadn't written more clearly what was on their mind if they wanted to communicate with us mortals. The teacher was in a much better position, as he possessed a gold standard, which was a handbook written by a scholar who had interpreted the poems the teachers used. I once got a low mark at an exam because I couldn't guess what was special about a poem where a woman got hurt to the extent that she became bloody. What was special was that the poet was a doctor, and he could therefore write about blood without constraints, as he was used to seeing blood.

Who knows if the interpretations are correct? Once, when an art critic had interpreted a painting, and the artist, Jens Jørgen Thorsen, was asked if he was right, he laughed and said he didn't mean anything with his paintings, he just painted and had fun while doing it.

According to my pupils, I did well as a teacher but not according to my supervisors. I was told they could let me pass but with an evaluation that could make it difficult for me to get a job. They preferred to fail me to give me a chance of thinking about whether I really wanted to work as a teacher.

This was the only time I ever failed an exam, but I am immensely grateful that my supervisors made this wise decision. I wasn't interested in my new profession and had invested far too little effort in it. As my university years had been easy, it never occurred to me that I needed to work in the evenings, which I found out my more successful colleagues had done.

I had no idea - and still haven't - that teaching was so complicated. I taught Swedish at an evening school, and in Sweden, I had been a teacher for two months at Norrmalmskolan in Piteå, 100 km south of the Artic Circle. Later, I lectured at the University of Copenhagen in the theory of science for over 20 years and became a professor.

To teach at a university required no qualifications, but an obligatory course in pedagogics came along that you needed to attend at some point. It took a week, and no one would dump you. My students at the university appreciated my lectures, which they often showed by clapping their hands when they were over.

I have lectured all over the world, which I have enjoyed. In my curriculum vitae, I have listed 148 lectures at pre- or postgraduate courses and 473 other lectures, including many public ones, 445 of which were invited lectures. I have lectured in the European, UK, Dutch and Danish parliaments and at two EU Commission meetings.

I would hardly have received all these invitations if I couldn't teach. The biggest audience I had was 4,000 doctors in Rio de Janeiro in 2016. They paid for my travel and hotel, just for this one lecture: *Why so few patients benefit from the drugs they take*.

It was an otherworldly experience for me to be a gymnasium teacher. I became worried I might be developing schizophrenia. Genetic research has rejected the idea that it is a hereditary disease, but back then it was believed, with reference to unreliable twin studies,[23] that the risk was about 10% that the off-spring also developed schizophrenia.

In the classroom, I sometimes saw myself as two different persons. One did mechanically what he was supposed to do; the other said to the first one: What on earth are you doing, why are you wasting your life? I didn't hear voices, but I was very worried as my private life had also become stressful because of a breakup with a girlfriend. Leaving the gymnasium cured me and I never worried again about any psychiatric issue.

It is difficult to be young. Life is a constant challenge. Becoming old is a blessing because you know what you are doing and why.

In 1976, I bought a lovely 4-room apartment at Halls Allé 12 in Frederiksberg with a tiny garden in front. In 1979, I attended a French language course in Caen in Normandy during the summer holidays. The last weekend before I went home, I hired a car and dined with two other Danes and two Brazilians at two good restaurants. I was so impressed that food could be so good that I still remember the name of the restaurants, "Hotel de la Poste" and "Auberge du Vieux Puits." Back home, I joined an advanced cooking course, which I enjoyed for four years till I moved out of the city.

In 1978, I met with Nina Richter at a party. We had met once before, in Bodil Richter's home, because they were related. It clicked and we immediately became lovers. We spent some months together but there was an issue I won't talk about that could not be resolved. One of my classmates had also been together with Nina and he became equally devastated as I did when it didn't work out. It took many years for both of us to come over it.

In 1982, my girlfriend was Susanne Weis Bjerrum. She moved into my apartment, and in 1983, I bought a 167 $m^2$ house at Ellehegnet 18 in Vedbæk. I have never been a city dweller and was happy to have nature close by again. But our relationship was not easy, and we split in 1984.

In 1988, I made the error of contacting Susanne again, as my love life had not been a success. We lived together for another three years, but the problems came back. There was something in her personality she could not control. He father was shocked when she one day told him how she behaved towards me. The behaviour has a name but I won't reveal it.

# 2 Drug industry insider

I have uncovered numerous cases of fraud and crime. Fraud is any activity that relies on deception to achieve a gain.[24] In the USA, you can be convicted of consumer fraud, which is deceptive practices resulting in financial or other losses for consumers during seemingly legitimate business transactions. According to Black's Law Dictionary, fraud becomes a crime when it is a "knowing misrepresentation of the truth or concealment of a material fact to induce another to act to his or her detriment."

After my defeat as a gymnasium teacher in 1974, I applied for a couple of odd jobs, one at Cheminova, a chemistry plant, and another at Dandy, a chewing gum producer, both in the other end of the country, which would have been similarly lonely for me as when I moved to Sweden. I also applied for a job as a biologist I wasn't interested in getting, something about water pollution.

My grandfather then suggested I went into the drug industry. I sent three applications and was called for two interviews.[25] The first interviewer had a dusty appearance, bald on the top with long whiskers that would have made him a perfect character in a Western movie, selling snake oil or whiskey. None of us felt comfortable.

The second company was the Astra Group, with headquarters in Sweden. I got the job and started working as a drug representative in April 1975. I spent seven weeks in Södertälje and Lund on various courses about physiology, diseases and drugs. I suggested that a course in "Information technique" more appropriately be called "Sales technique." The course leader did not reply, but it was all about manipulating doctors into promising to use the company's drugs. We learned how to increase sales through role plays where some of us played various types of doctors, ranging from the sour to the forthcoming ones, and others tried to penetrate their palisades and "close the deal."

One of our teachers told a story about a hotel that didn't sell many eggs for breakfast. A salesman suggested to place the eggs in a basket next to the cashier and when the customer came with the tray to pay, she would ask: "Would you like one or two eggs?" This increased sales substantially.

When I learned about drug usage, I thought: "Gosh, it's amazing that there are so many drugs and that they are used so much, for all kinds of things. Can it really be true that they are so effective that it justifies this massive use?"

I visited general practitioners, specialists and hospital doctors. It was deeply humiliating. I felt inferior, and the doctors sometimes treated me badly, which I fully understood. It must have been a nuisance for them to spend time with salespeople. There were so many firms that they could have several visits every week.

The academic challenges were miniscule, and I realised that my academic background would wither quickly if I didn't quit. The job also threatened my self-esteem and identity as a person. To be an effective salesman, you need to behave like a chameleon, adapting your personality to the person in front of you. The risk of playing so many roles and pretending to agree with doctors you disagree with is that you lose yourself.

I also disliked the culture, which was one of falsehoods. Because they had learned to manipulate people, many salesmen were womanizers, which they talked a lot about and practised during our sales conferences when their wives couldn't see what they were doing. Once, in Lisboa, some of my colleagues even went to a brothel.

According to Kierkegaard, losing yourself is the worst mistake you can make. If you deceive not only the doctors but also yourself, it becomes too painful to look in the mirror

and accept what you see. It is easier to be living a lie. It moved me deeply when I saw Arthur Miller's 1949 play, *Death of a salesman*, at a theatre in London in 1981.

I knew exactly what this was about, and one of my colleagues found his life so miserable that he hanged himself. He had told me of a clinical pharmacologist who accepted 100,000 crowns from a drug company – corresponding to more than my annual salary - for looking briefly at their registration application for a new drug, before they submitted it to the drug agency where she also worked and had a decisive role. I have a nose for corrupt people. I never liked this woman even before I was told this story and still remember her name.

The doctors I visited rarely asked uncomfortable questions, but a few times they told me I was wrong. Astra had developed a new penicillin, azidocillin, with the catchy trade name Globacillin, as if it cured everything. Astra sold it for acute sinusitis by telling the doctors about a study that showed the drug penetrated into the mucosa in the difficult-to-reach sinuses, which was claimed to be an advantage over usual penicillin. A specialist told me it was impossible to measure the level of an antibiotic in a biopsy, as one would also include capillaries in the sample where the concentration was higher. My company had fooled me.

Another argument for using the expensive drug was that its effect on a particular bacterium, *Haemophilus influenzae*, was said to be 5-10 times better than penicillin's. This claim resulted from Astra's laboratory experiments on agar plates.

Not a single doctor ever asked me if the results of these studies had been replicated by independent researchers, or if any randomised trials had shown that azidocillin was better than penicillin. There was no rational basis for using azidocillin. But marketing is effective. Astra succeeded to sell the drug for a while before they took it off the market.

After eight months as a salesman, I become product manager, responsible for written materials and the three-yearly sales campaigns. I once watched a meeting where the prices were fixed with the company's major competitor, which is of course illegal.

One day, one of my bosses, Torben Binderup Jensen, and I were planning for a meeting with two Swedish executives. I launched an idea he thought was excellent, but at the meeting, he presented it as if it was his own. He stole it, plain and simple. I was cautious not to make trouble, as I needed to be successful after my teaching fiasco, so I didn't say anything even though I was appalled by his behaviour.

Astra was respected among doctors, but the company deceived them. They sold a drug against asthma, terbutaline (Bricanyl), and tried to convince doctors that the patients needed not only constant treatment with pills but also with a spray. The argument was that it must be better to receive the drug both via the airways and via the blood. Yet again, the doctors didn't get any relevant information, which would have been the results of trials of the combination treatment versus treatment with either spray or pills alone.

Astra also tried to sell terbutaline as a cough remedy even though asthma drugs don't work for this.[26] The idea was to convince doctors to use terbutaline for smoker's lungs (chronic bronchitis), which is a big market. Astra produced a film showing the movement of small white particles in the mucus in the windpipe towards the mouth, and the story was that the cilia moved the particles faster on the drug. This was never documented.

I showed the film for chest physicians at Holbæk Hospital and felt very foolish. None of them asked if there were any randomised trials that had shown that terbutaline worked.

It is illegal to market a drug for non-approved indications (off-label use), but the drug companies circumvent the law. It is not illegal to discuss research results with doctors and say that they are allowed to use drugs for whatever purpose they find reasonable.

There is a huge market for over-the-counter cough medicines, but a Cochrane review of 29 trials with 4,835 patients showed that none of the drugs work.[27] But the researchers concluded that there is no good evidence for or against the effectiveness of the drugs for acute cough. Why is it so difficult for doctors to just say no to drugs that are not only ineffective but also lethal? During seven years, the US Food and Drug Administration (FDA) identified 123 deaths of children under six in its database.[28]

During my two years at Astra, I launched a new product, zinc lozenges, approved for treatment of venous and ischaemic leg ulcers and a very rare zinc deficiency disease, acrodermatitis enteropathica, which reduces the uptake of zinc.

The 20-page brochure I wrote was based on a similar Swedish brochure. Thirty-five years later, I compared it with the Cochrane review on zinc for leg ulcers.[29] The biggest study was published in a prestigious journal, *The Lancet*. The ulcers were healed after 32 versus 77 days in patients treated with zinc versus placebo. But the trial was excluded from the Cochrane review because it wasn't randomised, and it wasn't blinded either despite the use of a placebo! In contrast to the brochure, the Cochrane review found no effect of zinc. Like Globacillin, zinc lozenges disappeared from the market.

In 1977, I was offered a job at Astra-Syntex, a new joint-venture company between Astra and California-based Syntex. I established a medical department and was responsible for clinical trials and registration applications for new drugs and indications.

My boss was Bengt Arenhag from Sweden, a kind but naïve man. One day, he suggested we should make some private investments and took me to an office on Højbro Square. A man behind a huge mahogany desk explained that it was very safe to invest in silver, gold, whatever, because the prices only went one way, up. If we invested for 100,000 crowns, we could borrow the double amount from them and thus invest for 300,000, and they would keep the valuables in their safety boxes. This highly risky practice is called gearing.

I asked a simple question. If they were so certain that it would be prosperous to invest, why didn't they invest themselves instead of borrowing us money? I was also sceptical towards the idea that they, and not us, should keep the valuables.

The pompous desk-hidden guy was unable to give a reasonable reply. I kept my money, but Bengt invested and lost all his. It was a total fraud. The owner of the company, Mogens Hauschildt, just cashed the money. Six months later, he was arrested by the police and was convicted for fraud amounting to almost a billion crowns.[30] Twenty years later, Hauschildt was convicted of defrauding a widow for nine million and falsifying signatures, and he was on the run, wanted by Interpol.[31] What a character.

I had been happy to leave marketing but unfortunately, the industry's pervasive fraud and crime is also the norm in its clinical research.[32]

Astra-Syntex's survival hinged on naproxen (Naprosyn), a nonsteroidal anti-inflammatory drug (NSAID) used for arthritis. I did several trials with it and discovered I wasn't immune to company influence. There were many NSAIDs on the market, but you get so used to the idea that your drug *might* be better than the others that you end up thinking it *is* better.

When I asked the European headquarters in London why we didn't do a trial comparing naproxen with an analgesic like paracetamol (acetaminophen), e.g. in sports injuries, the medical director, physician Alan Pitchford, said they weren't interested in such a trial. He never explained why, although I asked on more than one occasion.

The reason was of course that such a trial would likely show that a cheap analgesic was equally effective but had fewer harms than naproxen. To lure doctors into preferring an

NSAID for paracetamol, all the drug companies gave them the impression - without having any good data to support it - that NSAIDs were more effective.

They used theoretical arguments, which are very convincing, even when they are wrong. Textbooks of pharmacology say that NSAIDs have anti-inflammatory properties, and even today the marketing message is that if you have a sports injury, there is tissue damage and inflammation with oedema, and treatment of the inflammation will speed up the recovery.

In 1978, I was contacted by Lasse Agerskov Andersen, a rheumatologist who had a part-time job with the Danish national football team. He wanted to find out if naproxen was better than aspirin for sports injuries. Aspirin is also an NSAID but is often used in low doses where it is assumed to have only an analgesic effect.

I wrote the protocol, and we did the trial, using low-dose aspirin despite the concerns of my boss in London. There were no differences between the two drugs, but this problem was fixed by the chief of Astra-Syntex's statistics department in Södertälje, psychologist Jan Wessman. He went on a "fishing expedition" to find something that could lessen the company's pains that naproxen wasn't any better than aspirin. Companies always do this when the results don't look good for marketing. Wessman was very apt at these "torture your data till they confess"[33] exercises. I found him creepy, a person who steamed of dishonesty.

The abstract of our paper says:[34] "There were no significant differences between the groups. Fresh injuries were over-represented in the acetylsalicylic acid group ($P < 0.01$), and when all patients were analyzed together, a significantly better treatment result was obtained the shorter the interval between injury and start of treatment. This might have influenced the results from this study."

So, at least indirectly, it seemed that naproxen was the best drug. What if naproxen had been better than aspirin and there had been more fresh injuries in the naproxen group? Would this reservation have made it into the abstract? Hardly.

We submitted our paper to *British Journal of Sports Medicine*. The editor, HE Robson, was surprised that Syntex had submitted the study, as our work contradicted the claims the company had made about naproxen being more effective than aspirin and paracetamol. We were startled that an editor so frankly sided with a drug company's commercial interests and his next remark made us laugh. He noted that 18 patients received aspirin during the first three days of injury compared to only 2 on naproxen. He suggested a more fair comparison could be made if we treated another group of patients, at least 16, with naproxen during the first three days after the injury. If we were willing to do this, he would reconsider our paper.

It would have been fraudulent to include another 16 patients on only one of the drugs in a randomised double-blind trial.

In my new job, I wondered from the very beginning if there was any proof that NSAIDs were anti-inflammatory, or if it was a marketing ploy. If a drug has an analgesic effect, it will lead to faster mobilisation, which would be expected to decrease the oedema. How could it then be claimed it also has a separate anti-inflammatory effect?

NSAIDs have some effect in rats whose paws have been rendered swollen and tender, but this doesn't prove anything. I often raised this issue, both internally and with rheumatologists, and I tried to find literature about it, but came nowhere.

Then I was lucky. I was contacted by orthopaedic surgeons who wanted to study the effect of naproxen in people with ankle distortions. I grabbed the opportunity to study also the effect on the oedema, which we measured by immersing the injured foot in water and comparing its volume with that of the other foot.

It was a beautiful study. We randomised 173 patients twice: to crutches or no crutches (mobilisation), and to naproxen or placebo. This factorial design is much underused despite its elegance. It can usually provide answers to two questions without needing more patients than if only one question is asked.

The results were convincing. The patients recovered faster when they were mobilised, which also decreased the oedema, whereas naproxen had no effect on the oedema. Thus, mobilisation was anti-inflammatory, and naproxen wasn't. This result was not welcomed in Södertälje, but Wessman tortured the data. He drowned our results in advanced statistics doctors wouldn't understand, presenting many P-values and omitting crucial data.

It was scientific misconduct. I have kept the data, and they are highly revealing.[35] After only 2-4 days, the difference in volume between the injured and the healthy foot was 42 mL when the patients were mobilised compared to using crutches (P = 0.01). There was no significant effect of naproxen (P = 0.42), and the difference of 11 mL compared to placebo could simply be due to more mobilisation because of less pain. Mobilisation also led to much faster recovery: 44% versus 16% had recovered after 2-4 days (P = 0.0006), but these data were also omitted from the published article that I had no control over.

Animal studies have shown that NSAIDs delay wound healing, so also for this reason, they should be avoided for sports injuries.

We submitted our paper to the *BMJ* (*British Medical Journal*) that rejected it, which is understandable, given that Wessman had left out the essential data. We also tried *Acta Orthopaedica*, a little-known Nordic journal, but its editors didn't understand how important our study was. The surgeons lost their patience and now just wanted to get it out. I couldn't convince them that it was too important to publish in Danish, but that's what happened.[36]

Years later, I was contacted by a researcher doing a systematic review of treatment of soft tissue injuries who said that our study was not only the largest but also the best one ever carried out. He therefore asked me for an English version.

Our study had wide implications. Nine years later, I got a serious ankle distortion during a tennis match and stumbled along in great pain during a trip to London to attend *BMJ's* editorial advisory board meeting. I moved with immense difficulty, seeking support from the house walls to lessen the pain. Another board member, Poul Glasziou, saw this and asked why I didn't use crutches.

I told him about our trial, which inspired him to do a systematic review of bed rest for all diseases.[37] He included 15 different conditions and found that it is harmful to immobilise people in a bed. When I was young, patients were routinely put to bed. Even patients with heart attacks were bedridden, to protect the wounded heart muscle, until research showed that bed rest killed them. Today, they are mobilised as quickly as possible.

In 1990, I published another revealing study. Patients with rheumatoid arthritis have inflamed and swollen finger joints. Thus, if NSAIDs are anti-inflammatory, they should reduce the swelling. But my meta-analysis of the placebo-controlled trials showed that NSAIDs did not reduce joint swelling measured accurately with jeweller rings.[38]

NSAIDs are not anti-inflammatory. The story behind this hoax is that when the newly synthesised cortisone was first given to patients with rheumatoid arthritis in 1948, the effect was so striking that some people believed a cure had been discovered.[39] The enthusiasm evaporated quickly, however, when cortisone's serious harms came to light.

The name - nonsteroidal, anti-inflammatory drugs - suggests that NSAIDs have dramatic effects like corticosteroids. It is extremely rare to name drugs after what they are *not* (non-

steroidal), but it was a carefully planned marketing ploy, and it worked so well that one in eight Danes get an NSAID every year.[40]

These expensive analgesics have killed hundreds of thousands of patients, primarily because of bleeding stomach ulcers and heart attacks.[41] I find it likely that none of those who died needed the drugs. Comparative studies have generally found NSAIDs to be no better than simple analgesics. A few studies are positive, but most are industry sponsored and their results have been manipulated. A trial of 300 patients with painful limb injuries that was not supported by industry did not find any clinically relevant difference in pain relief between paracetamol and an NSAID.[42]

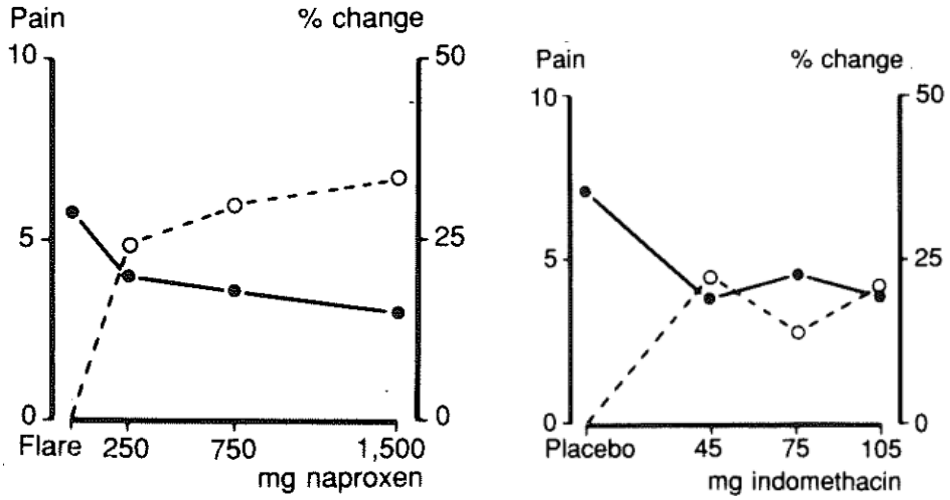
Unfortunately, it is routine that doctors advise patients with pain to take both an analgesic and an NSAID. But the combination is not better than paracetamol alone and NSAIDs should not be available over-the-counter, as this makes people believe they are harmless.

About 15 years ago, Danish TV focused on the liberal use of NSAIDs in football clubs. The sports doctors provided large supplies of the drugs, letting the footballers take as many as they wanted. There was a scandal, but as usual for scandals, it quickly died out. I asked to have a meeting with the director of the Arthritis Association who agreed with me that it was inappropriate to use NSAIDs for sports injuries. The Association launched a massive and effective campaign to get the drugs out of the clubs.

Astra-Syntex gave doctors lethal advice by telling them to double the dose of naproxen, from the standard of 500 mg daily to 1000 mg, arguing that the effect increased linearly with dose. This had apparently been shown in dose-response trials, but it wasn't true.

None of the trial reports presented any graphs. Instead, a significant linear relationship between dose and response was claimed, which gives the readers the clear message that by doubling the dose, they double the effect on pain relief. This was fraud, which I revealed by constructing dose-response curves for several NSAIDs (black circles are pain values, white circles are the mean improvement for all the outcomes).[43]

The difference between 250 mg and 1500 mg naproxen is six times in monetary terms but only 1.0 cm on a 10 cm pain scale, which is irrelevant. The smallest effect that can be perceived with this scale is 2.3 cm in patients with chronic pain,[44] and 1.7 cm in patients with acute pain.[45]



Increasing the dose increases the risk of dying, and several NSAIDs were later withdrawn from the market because of their toxicity, e.g. benoxaprofen, indoprofen, rofecoxib, ketorolac, tolmetin, zomepirac, suprofen, valdecoxib, and lumiracoxib. These drugs had been marketed with mendacious claims such as excellent gastrointestinal tolerance, proven gastrointestinal safety, hurts the pain not the patient, and least possible side effect profile (which can only occur if you don't take the drug).

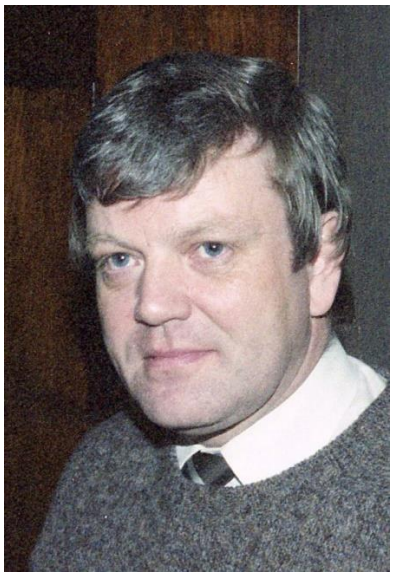
After having worked at Astra-Syntex for two years, I decided to leave the industry and I chose the most arduous way out.

I started studying medicine in January 1978 while I still worked for the company. I asked for permission to attend courses in 10% of my working time, but did not reveal to my boss that I had matriculated at the university, as I was afraid, he might then not allow me this freedom. This later became 33% and 50%.

During this time, I was offered a job as clinical research director for the Nordic area, in Astra's headquarters in Södertälje. It would have earned me a huge and well-equipped Volvo and a corresponding salary, but I preferred to finish my studies. It is surprising how effective you can be when there is little time. I finished my medical studies in the summer of 1984, left the company and started working at hospitals in Copenhagen.

It was tough to work while taking my third education. I still have lively dreams that I study medicine again to improve my marks. Sometimes, I tell myself that I am stupid because I am so old that I will retire before qualifying. Surely, I was under greater stress than I realised. I was very diligent, and when a book was recommended, I often read two books. I ploughed through 20,000 pages to become a doctor, got high marks, and it stuck well.

The last two years of my studies, I worked as a free-lance consultant for Astra-Syntex, earning about double as much per hour as if I had continued my employment. The deal allowed me to work for others, too. In February 1984, I became a consultant for a start-up company in Odense, Durascan, headed by Steen Græsted Larsen who had worked in the drug industry for many years after having skipped his medical studies.



Steen

My home office, no PC yet

Peter

Steen asked me to go to Odense and look out for a short man with a Russian fur hat at the train station. He wanted to import off-patent drugs and sell them at much lower prices than the original drugs, and he needed someone to get the generic drugs approved by the Nordic drug regulators. This involved writing applications and suggesting texts for the package inserts and packages.

Steen sent me a contract proposal I discussed with my lawyer who warned me against working for someone who used expensive stationery when starting a company. But I use lawyers for getting advice, not to make decisions for me, and as I had confidence in Steen and his project, I went ahead.

We became friends and had a lot of fun, particularly when I used the Danish Drug Agency's arguments against themselves. In 1987, they "expressed concern" that Steen's allopurinol tablets did not divide equally in the middle, at the division notch. We compared his tablets with the drugs on the market, and I wrote a statistical report where I "expressed concern" that none of the other drugs divided equally either.

I also argued that, since allopurinol was used prophylactically to prevent gout and should be taken for a long time, its steady state concentration could not fluctuate enough due to the tablet spitting issue to have any clinical importance. I attached an article from *The Lancet* showing that problems with tablet breaking are common[46] and noted that none of the drugs passed the requirements in the European Pharmacopoeia for dosage precision.

My reply was polite and friendly, but it upset the "concerned" employee so much that she became even more unreasonable. I continued to reply politely, with our subtle type of humour, and eventually, her boss, clinical pharmacologist Per Juul, got enough of this and overruled her. He declared we didn't have a problem and approved the drug.

The episode reminded me of my first boss at Astra-Syntex, Knud Binfield, who once said: "Pharmacists have small minds. They are educated to think in milligrams!" The pharmacist at the drug agency was obsessed with splitting tablets, and I used a formidable amount of time demonstrating, again and again, that there were no problems with any of our drugs.

In 1988, I wrote a pedagogical letter about pindolol to the drug agency, which had mixed paired with unpaired observations, which I found statistically "concerning." I recommended the agency to use our method instead and added that, "The agency's assumption, that it would be relevant for us to have a better process control, stems from material we cannot evaluate. It would be an advantage, if the agency would expand on its often very brief responses, with relevant data about methods and sample sizes, particularly in relation to launching such a far-reaching assumption."

In 1989, we still had hair splitting issues with the agency whose work was sloppy. They noted that the production of amiloride tablets was unsatisfactory because they had found a relative dispersion of 20% for the split tablets, but they did not say what their sample size was or showed us their data. I replied that we found a dispersion of 11% when we divided 50 tablets, which we believed was acceptable and had already informed the agency about. I demonstrated that our drug was not any worse than other amiloride tablets and advised the agency that a judgment about tablets should not only be an issue for pharmacists. There needed to be a clinical judgment, as the issues rarely had clinical consequences.

All this "finding a hair in the soup" theatre was a total waste of time and resources. In 2022, a review of 101 research articles concluded that no substantive evidence was found to support concerns regarding loss of mass or weight variability.[47]

I really liked Per Juul and published an article with him and another professor of clinical pharmacology, Eigill Hvidberg, about dose-response relationships, in which I launched a new

term, dose-response bias.[48] It occurs when two drugs of the same class have not been compared in equivalent doses, a trick the drug industry often uses. If they want to show that their new drug is better tolerated, they overdose the old drug. They can then show that the effect is the same whereas the old drug causes more harms.

In our submission for furosemide, a diuretic, we included a bioavailability study from Italy, which compared the serum levels of the original and the generic drug in the same human volunteers. Peer Juul called Steen and pointed out that he had worked with this drug and had never seen so little fluctuation in serum levels. He did not say directly that the study was made up, but we withdrew the application and dropped the fraudulent study. Instead of doing a new study on the highly fluctuating serum levels, I suggested to compare the drugs' effects instead. Forty volunteers peed for us every hour, and our drug was approved.

I did many bioavailability studies. I wrote the protocols, analysed the data, and wrote the reports while one of Steen's friends, general practitioner Mogens Zarling, recruited the volunteers and collected blood samples. During a dull holiday in Morocco, I read a book about advanced features in Quattro Pro spreadsheets and constructed an elaborate series of macros. When I had defined a few key characteristics, like number of participants and measurement times, I pushed the button, and the macros did all he work for me. They calculated the area under the serum concentration curve for all the volunteers and printed the graphs automatically, with appropriate legends and both drugs in the same graph.

I kept the studies and reports very simple. The text was often just 6-7 pages. In contrast, commercial companies wrote huge reports - sometimes hundreds of pages - to justify their huge honoraria. Their reports were full of irrelevant data, e.g. data on haemoglobin, sodium, potassium and a lot else that don't have anything to do with comparing serum levels of two drugs in healthy volunteers. I often found errors and sometimes fraud in the reports.

At times, we suspected that some employees in the drug agency were not just incompetent but corrupt, e.g. when they rejected our bioavailability study of maprotiline stating that the sample size was too small, with no explanation whatsoever. I documented at length, with statistical methods and arguments, quoting the agency's own guidance document, that the rejection was unwarranted, and our drug was approved.

We were once asked what the blood loss was in a bioavailability study. Well, we didn't exactly plan to exsanguinate the volunteers, and it would have taken the agency two minutes to find out that the blood loss was minimal, by looking at the protocol we had submitted.

I found out that a 240-page bioavailability report of flunarizine was fraudulent, so we didn't use it. The fraud I identified was particularly prevalent in Italian studies. In two Italian studies of acetylcysteine, all baseline values in two compared groups were identical, which is impossible. I also discarded an acyclovir study. The standard deviations were wrong; all blood samples were drawn at exactly the right time, down to the second; and the standard 95% confidence interval had been replaced by a 90% confidence interval because the former did not meet the regulatory requirements.

Steen imported his drugs from two colourful billionaire brothers, Thomas and Andreas Strüngmann, who had inherited their father's medical company in Tegernsee in Bayern. I visited them a couple of times. One day, when Thomas passed by a Mercedes dealer, he said: "Oh, I almost forgot I had promised my wife to buy her a new car today." He went into the shop and bought one. He might just as well have said he almost forgot to buy bread at the bakery.

One day, when I had received a strange bioavailability study on atenolol from Tegernsee, I wrote back that, “My dismay is caused by my knowledge that people employed by the drug agency are about as stupid as I am and would probably also react to this. Much confusing paper to describe a few facts. I do not remember ever before having seen a bioavailability study I cannot understand. Please help me.”

Steen found my “tone condescending, arrogant and student-like, precisely a style that can make our friends in München backfire totally. I think you should be factual, friendly, and jovial, no matter the amount of garbage that might come our way ... I fully understand your irritation … and I can also see the humour in your fax because I know you, but it will feel seriously provocative for a couple of self-congratulatory and self-satisfied Germans.”

The weird report came from Professor Sandro Gay in Lugano who wrote to Steen: “I think your friend did not understand our study since he has not sufficient experience in this matter. Now, I’ll try to explain shortly what your friend did not understand.”

That really made me laugh. I was an expert on bioavailability studies, but Gay was right that I have difficulty understanding what I should make out of garbage.

Gay was not the only impolite person. At one point, I had so many unanswered questions the Strüngmann brothers had ignored that I went to Bayern and spent three days with them and their expert on regulatory issues, Thomas Strittmatter. I got some of the data I needed, but Andreas told Steen my trip had not been worthwhile. I contained my temper and reminded him of issues with seven drugs where I still needed information from him.

Another person in Tegernsee, Spiess, was also difficult. I alerted him to error after error in bioavailability studies he had been involved with. His attempts at explaining away the errors he had made were total nonsense, and, on top of this, he considered me dumb. I suggested to Steen that Spiess should attend a course in elementary statistics.

Once I wrote to Andreas: “Please avoid ‘Entsprict’ [fulfilled] in all quantitative analyses.” I sometimes wondered if all the stability tests had been carried out because they take several years for every single drug.

It is difficult to start a drug company without investors, and my contract with Steen stipulated that I would not get paid before a drug came on the market, and then only a small sum every month for some years. Early on, he nonetheless owed me 50,000 crowns for my bioavailability work. As he had a financial deficit, he asked if I was willing to convert the money to shares in his company.

It was not clear if his company would survive. Big Pharma did what they could to strangle him. One company ensured he could no longer borrow money in his bank, which it accomplished because it was a big customer. And many doctors were unbelievably arrogant. They said they wanted to support the researching industry and not pirates like Steen. The fact that the companies had already earned copious amounts of money before their patents ran out didn’t matter to them. It is easy to be morally indignant when you use other people’s money for it and when the “researching industry” tells you what your opinion should be and pay you handsomely for stating your “independent” opinion.

Since I had bought a big house in Vedbæk in 1983 that was way more expensive than my salary as a soon-to-be doctor could match, I felt I needed the money. I declined Steen’s offer, which was very foolish. I am usually prepared to gamble if the risk is small compared to the possible win, but I abstained from it this time. If I had accepted the offer, I would have earned 50 million on the shares when Steen sold his company to Astra in 1994.

I don’t complain. I have always had enough money to do what I wanted. I worked for Steen for ten years and earned what corresponds to over six million today.

Steen was a generous and unique leader. He said that since his salesforce generated his income, they should all have a Volvo 740, which only the directors had in other companies. When I needed a new car in 1987, he persuaded me that I should also have a Volvo 740. He took me to a car dealer and found one, two years old, with automatic transmission and electric sunroof, which cost me a full-year's salary *before tax* as a hospital doctor.

I don't have any interest in cars, so when I went to work at hospitals in Copenhagen in my luxury car, I had not expected it would become a gossip subject. The other young doctors wondered how I could afford such a car, and I said some people are luckier than others.

Over the years, Steen told me the most fantastic stories about his career and I persuaded him to write a book about it. Unfortunately, he did not finish it before he died in 2022. He was a pioneer, a visionary leader, an innovator, and a dear friend. He and his staff made all the ads themselves instead of paying advertising agencies to do them, and they were totally different to the nauseating ads from other companies.

I did some work for other companies and for an employee at the Danish Drug Agency who paid me out of his own pocket. I never figured out what kind of trouble he was in.

In 1986, Karsten Højholdt, who had many years of experience from the drug industry, invited me to join him when he established *Scandinavian Institute of Medical Advisers Ltd*. He involved nine doctors and a scientist who could measure serum levels of drugs with mass spectrometry. He had grandiose plans and used the same expensive stationary as Steen, but this time, I was sceptical.

To say the least, I was surprised when we were all asked to invest money in the company to cover salaries to Højholdt, a secretary, a lawyer, an accountant, rent, and other expenses.

Two of the ten people withdrew already before the second meeting. After having seen Højholdt's budget for the first year, I also pulled out, which was a good decision. In 1996, the revenue was 15,713 crowns,[49] and the company was forcefully dissolved in 2002.[50]

Højholdt once asked me what the requirements were for registering a cholesterol-lowering fibre product in the Nordic countries, Western Europe, and the USA. I had only five days to do the work. I called Per Juul, got some advice from drug agencies, and found the US requirements in official documents. I submitted a detailed report that told people what they should do, including which clinical trials that were needed. I took only 7,500 crowns for this work, which must have been very valuable for the requesting company.

Astra-Syntex asked me to write a registration application for getting naproxen approved for various pain conditions. They sent me 24 trial reports and other documents and offered me 25,000. Unfortunately, the company succeeded. Naproxen is approved for mild pain conditions, but as explained above, it is far too dangerous for that. I should not have helped them.

A rheumatologist told me that if patients with rheumatoid arthritis think they need an NSAID, it is because they have not been treated adequately with disease-modifying drugs. NSAIDs should be taken off the market so that no one can use them. They are a major killer.[51]

# 3 Exploring Kenya and South America

In 1980, I didn't know what to do for my summer holidays. I found an advertisement in the newspaper for a one-month expedition in Kenya under primitive conditions.

I always wanted to do this. As a child, I read many books by famous explorers. We would sleep in tents and travel around in an old military truck, bought at an auction in Frankfurt and painted white. At the introductory meeting, we were not informed about tropical diseases and other dangers, e.g. robberies, which not so rarely were murderous. We didn't know either that the company owner, Ole Hilby, had a shady past involving the police, and that his tours were irresponsible, with no safety precautions.

I was the only one who came prepared. I had read books about tropical diseases and had asked my doctor to prescribe the most necessary drugs. He refused, saying we should consult a doctor if we became ill. Great advice for those who are far away from a doctor.

We didn't know Kenya is a dangerous place, but we learned it quickly. And upon my return, one of my fellow medical students told me about four young Danes he knew that were attacked near Kilimanjaro where they camped around the time we were in Kenya. Some Massai broke into their tent and murdered two of them while a third was scalped when the machete hit the top of his head.

In Nairobi, we met our driver, Rudi Carstensen, a mechanic and previous United Nations soldier in Congo. He was from Haslev, and my grandfather had assisted at his birth. Another participant, Else Kjeldstrup, met my mother on a plane to Switzerland shortly after the war.

There was plague in Nairobi, but we were only there for a short time to buy food, which was scarce. There were long queues and a serious shortage of bread and flour. The little bread we could buy during the trip wasn't enough. Each of us lost 4-8 kilos and needed to eat what we had even though the bread turned green and black because it moulded.

We visited the farm Karen Blixen owned from 1914 to 1931 and stopped for the night in Karatina Town, 130 km north of Nairobi, where there was a little tent in a large open square. A man in a colourful jacket ran up to us ensuring eloquently that it would be perfectly safe to camp there. The people in the tent had another view. They were civil servants from Nairobi. They said that since the square was close to the main road, rumours would travel quickly about our presence. They advised us to contact the police, and we put up our tents outside the police station. The colourful jacket had difficulty hiding his disappointment.

We woke up during the night to the sound of low voices outside. A woman screamed, and the sound of footsteps faded away. Luckily, nothing was stolen from the open truck.

We were assigned various tasks, one week at a time. For example, one collected firewood, and one cooked tea several times every day, as we didn't dare drink the water.

In Nanyuki, someone spoke Danish to us. Inger Jacobsen had lived in Kenya with her husband Orla for 26 years because the heath dampened the arthritis pain she acquired after a rheumatic fever. They had a farm, which presented many challenges. The leopards took 7-8 calves a year and as they were protected, they needed to catch them in traps and release them elsewhere. Guards looked after cow thieves, but they sometimes supplemented their income by collaborating with them. Elephants regularly destroyed a good deal of the crops and the fences. To protect against assaults and robberies, Inger and Orla had seven German shepherds they let loose at night. There were frogs beneath the floor planks and therefore also snakes, which killed some of the livestock.

All the 25 workers at the farm had intestinal worms, and they were dewormed once a year. We were therefore careful with hygiene and with cooking the meat sufficiently.

It was very difficult for Inger and Orla to make ends meet, and they were rarely in Denmark because of the tight currency restrictions, which would make it close to impossible to sell the farm and get the money out of the country.

Orla was very well liked by the locals, but 12 years later, he was murdered, likely with a hammer.[52] The police didn't find out why or who did it. He was last seen in his car with two Kenyans who drove him into a forest, killed him, and abandoned the car.

We went further north, and when we came to the Samburu Game Reserve, 118 km from Nanyuki, we were stopped by a group of soldiers at a roadblock who looked out for Somali guerilla forces.

In the game reserve, we couldn't find any camp sites. The few signposts we saw were not of any use because they had been overturned by elephants. We therefore stayed in huts a few hundred metres away from the game lodge. Whenever we walked between the huts and the lodge, we were escorted by a guard with a spear.

The next morning, I went down a little hill to study insects in the bushes. I suddenly realised that one of the pointed leaves didn't move in the wind. It was the horn of a buffalo. Everything I had learned about the unpredictability of buffalos and rhinoceroses and about staying calm passed my mind, but I was scared and ran as fast as I could up the hill. Looking back, the buffalo was still standing in the same place.

Later that day, we noted that a little Peugeot followed us. Inger stepped out of it and said she wanted to join us to see parts of Kenya where she had never been. The driver had found us by following the wheel tracks, a remarkable feat considering how erratic our journey had been the previous day, and also because the landscape was very dry.

We continued northbound and camped close to Mount Ololokwe, 340 km from Nairobi. Steen Andersen, a school pupil, showed me a huge, hairy spider that was sitting on his arm and asked if I was interested in getting it for my collection. I wasn't, so he brushed it off and trampled on it. Susan Jakobsen saw this and was terrified. She wanted to take the first plane back to Denmark, but we were out in nowhere. Rudi did his best to calm her down and he was very good at it. They later married.

There were many scorpions, and we heard a lot of scraping and scratching outside and beneath the tents at night, but Susan got used to it after a while.

In Marsabit, we encountered several elephants in the forest and waited patiently for them to leave the road before we moved on. On one occasion, however, a big male came storming back towards us, breaking tree branches and trumpeting, so we threw ourselves to the floor of the truck while Rudi speeded up and escaped.

At night, Bernt Gregersen suddenly shouted loudly from his tent. He had entered his sleeping bag without turning the torch light on and had been bitten by big ants that had made their way through the ground sheet of the tent into his sleeping bag. He slept outside the tent that night, which is not a wise thing to do in Africa.

We headed west, through the Koroli desert. It was impossible to find the entrance road without being helped by a local guide. We didn't know it was a dangerous route; or that we needed permission from the provincial headquarters to drive thought the desert; or that at least two vehicles must accompany each other.

It took three hours to drive just 50 km because of the sharp lava rocks. After this, it was all sandy, then a stone desert, and then sandy again. The track disappeared several times, but Rudi found it again by going west.

The motor broke down, at the worst possible moment, in the middle of the desert, and Rudi couldn't repair it. We had only 115 litres of water and had not seen any cars on our way. It was also a long time ago we had seen any natives.

A chaotic and fierce discussion ensued. People were scared and felt something needed to be done. If we waited, our water supply would run out and we would not be able to send anyone looking for help. And we wouldn't be missed for the next three weeks. This was many years before we had mobile phones, and we didn't bring a radio sender.

The atmosphere was panicky, and at no point in time were the different possibilities weighed against each other. I knew that the best thing one could do was to stay at the car and hope someone would find us, but I was overruled.

Steen and Bernt volunteered and started walking at 5 p.m. carrying only a map, a compass, a little bread, and two litres of water each even though the temperature was $35^0$ C. Rudi stared after them for a very long time, and Inger said we should not have let them go. She knew a Kenyan family whose car also broke down and they all died.

Then we got a shock. We thought that Steen and Bernt should walk "only" 50 km, but everything had been so chaotic. When we looked closer at the map, we found out that it was about 100 km, unless they cut a corner, in which case it was 80 km. It was impossible to walk that long in the sand during the night, so they would also need to walk the whole next day, without water.

We discussed the situation again. If we didn't hear from Steen and Bernt, should we then send two more volunteers and when should we do that?

Rudi was our leader, but he gave up. I took over the leadership and rationed the water. Night came, and it was still very hot. Inger couldn't sleep and kept thinking of the family that died in the desert.

The Koroli desert

Hindrance in the forest

Steen and Bernt only sipped a little water now and then. The thirst came quickly, and after 30 km, Steen had become confused. He looked at the map but couldn't make use of it. He didn't realise he had turned it upside down. The compass stopped working, likely because there were magnetic stones in the desert, but they were lucky. The bright moon enabled them to navigate after a distant mountain.

After six and a half hours, the trail divided, and they didn't know where to go. They left a message under a stone that we found later: Went north at 23.25 Bernt and Steen.

Steen's condition deteriorated. He developed delirium, walked erratically and spoke in a way Bernt couldn't understand. He suggested they went to sleep or made a shortcut by going north-west. If they had done that, they would likely have died.

Bernt's feet were full of blisters, but he carried on. In his confused state, Steen thought he saw a lion and even Bernt was in doubt, but it turned out to be a bush.

Steen took off his pants and said: "What if we meet someone while I walk around in my underwear?" to which Bernt replied: "I certainly hope so, this is why we walk here!"

Steen became a little better, but Bernt realised that they might not survive. He usually didn't say much but started talking in an incoherent way about his life, in particular some boat trips he had made on a lake in Ghana, perhaps because he was very thirsty. He also thought he saw a rhinoceros, which was extremely unlikely as poachers had killed almost all of them.

The sun went up and they had no water. Bernt thought he could hear water roar in Lake Turkana. He hallucinated.

Finally. They saw a camel and went towards it. They met a couple of camel drivers and paid for some brown, stinking water one of them carried with him in a camel bladder.

They thought the natives wouldn't be of much help and were convinced they were close to the mission station in the oasis at Loyangalani. They therefore marched on but quickly regretted their decision. They should have asked the natives to help them.

Then they were lucky for the second time. A police patrol that was on the lookout for Somali guerillas came by. The police found their story unbelievable and told them it could take a very long time before a car would pass by the spot where our truck was and gave them some water.

The patrol leader said Loyangalani was only a few miles away and he asked his colleagues over the radio to come down and pick Bernt and Steen up.

They waited under a bush, but after a while, they started walking again. After an hour, they had no more water, and the heat was unbearable. What did the police officer mean when he said a few miles? In Africa, a few miles can mean a lot of miles.

The police didn't come.

When you walk in burning sunshine, you lose at least half a litre of water per hour, and sometimes a good deal more. You won't survive for long. Bernt and Steen dragged themselves on knowing they would soon collapse.

Then they were lucky for the third time. Their rescuer was madame Sapieha, of German descent, who arranged photo safaris. She had driven 3.5 hours south from Loyangalani in her car, which the police officer had called "a few miles." She took Bernt and Steen with her, changed her plans, and drove into the desert to find the rest of us.

When she arrived, she asked who our leader was. Rudi replied somewhat resignedly that, in a way, we were all leaders. Sapieha blew him up. It was unforgivable that we had sent two people away with too little water, and with the risk of meeting wild dogs, leopards and lions, of which there were quite many. The lions were particularly dangerous in that part of Kenya because they had got used to eating the corpses left behind after the skirmishes between Somalis and Kenyans. Moreover, they could become so desperate of thirst that they killed people just to drink their blood. This was why the natives were always armed with two spears each and never walked alone.

Sapieha left some water in our camp and offered the back seat in her car to Rudi and me, as we needed to find a phone connection to Nairobi and arrange for another truck to be sent up to us. We were dirty and long bearded. There were three photo tourists in the car, young

Germans, nicely dressed in clean clothes looking like they were on a charter trip to Greece or on their way to a discotheque. They peeped timidly at us as if we were savages and didn't talk to us at all. When Sapieha stopped the car because she had spotted some animals, one of the men dispassionately shot a few shaky and much too short sequences with his film camera that couldn't be used for anything.

Later that day, when we rested while two Africans prepared the dinner, one of the Germans asked if he could take a photo of us. That was the first contact we had with him, and it felt weird. We understood why the Africans declined being filmed unless being paid for it.

Sapieha dropped us in Marsabit, and we went to the only hotel in town. There were no windows in the room, just open square holes in the wall, and when we saw a big spider in a corner, we asked one of the locals to drive us to the safari lodge in the forest.

The next day, it was difficult to find a driver who wasn't drunk, but we found one and went with him to the broken truck.

Only three people remained at the truck, the oldest ones. The police in Loyangalani, which had defied orders by not going south to find Bernt and Steen, had talked to Father Guiliano at the catholic mission station who had sent his Landrover to our camp. When it arrived, a kind of panic erupted, and the youngest people had quickly filled the car.

When the remaining five of us arrived at the mission station in the Landrover very late in the day, the young people sat in a palm garden and enjoyed cool drinks. After a long while, one of them came strolling down slowly towards us. This was over the top. We were sweaty, dirty, and exhausted, in very low spirits. They had run away the previous day and did not feel any kind of responsibility to come down and help us unpack. This created a rift that lasted for the rest of the journey.

Rudi had hired two locals in Marsabit to guard the truck against thieves but when they found out that the truck was unprotected, only covered by tarpaulin, even over the driver's seat, with nowhere to hide, they decided to go back to Marsabit in their car instead of ending up as lions' food.

Then, Rudi hired some people from Loyangalani and arranged for a car to be sent to them regularly with food and water. But already when the car returned to them for the first time, they didn't dare stay in the truck any longer because some lions had turned up that showed greater and greater interest in them.

It took two days for Steen to recover but he continued to suffer from terrible nightmares. The natives awed him and created a story that he had seen seven lions during his unarmed walk in the desert. We slept indoors but there was an unpleasant smell of dead insects and spiders, so Steen preferred to sleep outdoors, which I did not understand. I had seen many scorpions running around after dark. Worse still, Steen suddenly saw a snake less than two metres from him. He was perfectly still, as he watched every move of the snake. Then, there was a hiss behind him. It was another snake, lying on top of his bag, right behind his head. It went down and moved slowly across his sleeping bag and disappeared.

Steen did not sleep outside again.

It was very difficult to find anyone who would come up to the desert with a crane truck, but Rudi succeeded. The little goods that remained in the truck after we had left it had been stolen. We continued our journey in another military truck but without Inger. She did not need any more "adventures" and waited for a plane to take her back.

The plane came the next day, from the famous *Flying Doctors Service* organisation. The pilot, Dr. Spoerry, flew it herself on her monthly visits. She only had time to look after the

most serious or unclear cases, as she visited several places every day. The most common diseases were malaria, dysentery and bronchitis. On her previous visit, a woman had died after being bitten by a puffadder while she slept. The snake had creeped up between her legs to get some warmth. I wondered what Steen would have done if the snake behind him had crawled into his sleeping bag.

I saw patients together with Spoerry who was an amazing person. She was born in Switzerland and had been a member of the French resistance during the war. She declined to talk about herself: "It is the work that counts. Judge what I do." In 1999, I saw an obituary about her in my newspaper; she died aged 80.[53]

After our stay at Lake Turkana, we went south and arrived at the Aberdare mountains where the guerillas hid during the Mau Mau Rebellion against the British in the 1950s. The two guards at the entry gate to the national park were very happy to see us, as they hadn't seen other people for two weeks. The colonial times weren't completely forgotten:

"Are you German or British?"

"We are Danish."

"Oh, that's better!"

We camped near the entrance, but I felt a little insecure when I went peeing in the dark. Upon my return, I received strict orders not to leave the area between the house and the truck. About 200 metres away, 6-7 lions were busily eating after having killed a buffalo, and now I could hear them. Sometimes, a big sigh came from that direction, or I heard a big crack when a lion broke a bone. Then Bernt appeared. He also went out peeing, in the same direction as me, but further away. He needed no explanations.

Back in Nairobi, some of the youngsters went to a night club and three of them came back with three very noisy women. The next morning, a camera was missing.

The road between Nairobi and Mombasa at the Indican Ocean is asphalted and very good. Rudi did not want us to camp along the road, as there were many robber gangs. We found a hotel where truck drivers stayed overnight. The owner had never had white visitors before and asked us how we found his hotel. We showed him a map, with a big H on it. He laughed and said that this was a luxury hotel of European design a further 100 metres down the road. But we stayed at his place.

During the expedition, I took a full hour of film with an advanced Beaulieu super 8 camera. In the Tsavo National Park, I was so preoccupied with filming that I was unaware that I had become totally alone. I was close to a river, with big boulders, so I could not know if an animal was hiding behind one of them. I got really scared. When I went back and climbed a hill, I saw a sign that said it was forbidden to go beyond that point. Meanwhile, a group of German tourists had arrived at the top of the hill, and the native guide screamed at me:

"Why on earth did you walk down there? Don't you know that the big game come down to the river to drink?"

"Oh, yes, I know. That's why I went there."

"And then there are the snakes, too."

"I know, and I saw a couple of them down there."

We camped at the Aruba lodge, at a small lake inhabited by a couple of hippopotamuses. The guards warned us that lions and elephants often came down to drink. There were toilets 100 m away from our tents, and I went there after dark with two other people to brush my teeth. There was no entrance door, just an opening in the wall.

A little later, we heard some deep growling sounds. I signalled SOS with my torch in the direction of the truck where Tea Jakobsen, Susan's sister, sat reading, but to no avail.

Then a lion started roaring nearby.

A little later, Rudi came by and said the sounds had come from a hippopotamus. That would have been a biological sensation, a hippo roaring like a lion! I went to Tanzania in 2024 with my family, which confirmed that it is impossible to mistake the two sounds. Anyway, it wouldn't have mattered. Hippos are more dangerous than lions and come out of the water at night to graze. We came back to our tents and saw hyenas by the car a little later, and their howling disturbed our sleep.

Tea told us that she had wondered why we stayed at the toilet for so long and played with the light. Come on, we were very scared and looked for help!

We arrived at the coast where we were advised not to camp outside the official campsites. There was even more crime here than in the rest of Kenya. When we drove into a coastal town, the Africans laughed at us. In this tourist Mecca, they were not used to seeing dirty and unfashionable Europeans driving in a truck that should have been scrapped ages ago.

I wrote a diary and read aloud from it in the evenings, which was appreciated, so I continued to write and didn't rotate to other jobs every week. As our trip had been so dramatic, some of my companions suggested I wrote a book about it, which I did. It was a bit arduous to write a book on a typewriter, as I needed to rewrite it a couple of times.

I published it in 1985.[54] As I had no experience with publishing books, I accepted a contract where I would only get 15% royalty if sales exceeded 1600 copies. As only 639 copies were sold at full price (and 1132 additional ones for one third of the price), I wasn't paid anything. It wasn't a fair deal, but my book is on the shelves in public libraries.

Shortly after I had come back to Denmark, the police contacted me because Hilby, the owner of the company that sent us to Kenya, had tried to cash fake checks using my name and bank details. I found out that others had described him as an unrealistic daydreamer with great plans for Africa if only people would support him with a lot of money. One noted that investors had lost all the trucks he leased.

This was not the only surprise. About a month after my return, I developed malaria of the deadly variant (see page 465).

**South America**

In 1985, during my holiday on Mallorca, I met a Brazilian girl, Tania Maria Guida, at a discotheque while ordering a beer. She and her cousin, a girl from Portugal, were very nice talking to but nothing more should have come out of this, as it was their last evening. But Tania and I exchanged addresses and started corresponding. She suggested I learned Portuguese and came to Rio de Janeiro to visit, and I thought: Why not learn Portuguese, too?

I took lessons once a week for two years, and when Tania went to see her cousin in Algarve in 1987, I went, too. We established a romantic relationship but she refused to have sex with me, which I found very annoying and antiquated, as sex is a natural thing like kissing and caressing. She said only the animals did this. Yes, and I am an animal.

A year later, I went to South America for a four-week vacation to see Tania again, practice my Portuguese, and see Brazil and neighbouring countries.

In Rio de Janeiro, Tania drove me around to the tourist attractions. We passed the Tijuca forest, but she didn't want to go in there because there were over 20 murders every day in

Rio. She constantly warned me about the dangers. No one stops for a red traffic light at night. She also said I should not take a bus. However, one day I wanted to see the National Museum and boarded a bus. As soon as I had come in, I saw three men entering the bus at the rear end whom I would not like to get in contact with, and they looked in my direction. I jumped off the bus, just in time before it set in motion.

One evening at the Copacabana beach, I was robbed. I had a little money in my shirt pocket, and suddenly, a guy came up from behind and tore off the pocket while some bills flew around. I bent down to collect them, but they were totally worthless. It was really smart. If he hadn't done that, I would instinctively have run after him, which could have been dangerous as many robbers were armed with guns or knives.

Tania and I got along well, without being intimate as in Portugal, until we dined with one of her friends who kissed me goodbye on the mouth. She was very pretty, and Tania became jealous even though I wasn't her lover. Her beautiful friend rang Tania afterwards and said she would like to see me again, but Tania ensured it didn't happen. She became very sour and stopped driving me around.

The friendship was over, but it didn't escape me that Tania wore a low-cut dress the next day displaying her female attributes. The kiss wasn't my fault, but after this, she cut me off totally and didn't reply to phone calls even though I was still in Rio.

I went to Paraguay, which was a strange country. Alfredo Stroessner Matiauda had been the country's dictator for 34 years. Soon after taking office, he placed the entire country under a state of siege and suspended civil liberties.[55] The provisions allowed the government to arrest and detain anyone indefinitely without trial, as well as forbid public meetings and demonstrations. He murdered thousands of people and created a haven for Nazi war criminals, including Josef Mengele, the "Angel of death" from Auschwitz.

People in Asunción, even those who opposed his regime, told me there was less crime in Paraguay than in neighbouring countries, which could be true, given the brutal dictatorship.

The population seemed to live on drugs. There were more pharmacies than restaurants, food stores or banks. There were also numerous electrical stores with many different transformers, but I couldn't find one that fitted my super 8 camera. I had covered my rucksack with chicken wire to prevent theft but in Rio airport, my transformer was stolen. I therefore couldn't use all the film I had brought along. Everyone I have talked to who have been to South America has had something stolen. This is something you need to accept if you want to see this part of the world.

I went to Manaus in Amazonia. I practiced my Portuguese by talking to the locals. Sometimes, both in Rio and in Manaus, people you met were prostitutes. There was widespread poverty, and the prostitutes I talked to were ordinary people who just happened to be so poor that they resorted to this source of income. Some were nice and attractive, but they accepted when I declined their offers and just wanted to talk as I did not want to run any risk of getting HIV. In Manaus, the prostitutes were very upset because one of them who was HIV infected had mixed some of her blood with ketchup to infect others. At least that was what the rumours said, but they didn't know that you cannot be infected this way.

I took a boat into the jungle via a little travel agency. I got acquainted with the cook on the trans-Canadian train and his wife, but after I told them a joke, they didn't want to talk to me again.

Gary Hart and George Bush were both running for president, and Hart had a mistress, Donna Rice.

"Donna Rice, whom will you vote for?"

“That is very difficult for me, because I have Bush in my heart but Hart in my bush!”

In the jungle, I was going to sleep in a hammock under a mosquito net, and I noted that the palm roof was full of spiders and there was also a black scorpion. When I told the Indian about the scorpion, he said: “What do you expect? This is its home.” When I lifted the net during the night to go peeing, a big spider fell off it. I didn’t sleep too well. A primitive jungle life is not among my favourites.

I arrived in Campo Grande in Southern Brazil on a Sunday. In the evening, there were very noisy revivalist meetings everywhere that lasted several hours, and I went to one of them to see what they were about. It was spooky. Several preachers replaced one another to keep the mass hysteria going. They all wore suits despite the heat.

Some of the hundreds of attendants came up, grabbed the microphone, and told the audience about the miracles they had experienced. All arms came up, again and again, as if it was a Nazi meeting heiling Hitler, but it was Jesus they worshipped. People applauded all the time, with twisted faces, almost crying, in increasing ecstasy. My Portuguese was good, but if I had told the crowd that religion is the biggest hoax the world has ever seen, I might have been lynched or at least severely beaten up. It was a mass psychosis and the preachers talked about money and donations all the time, just as they do at similar fanatic gatherings in the USA. This was the worst I had ever experienced in terms of religious insanity.

I had planned to take the night train to Corumbá but after having seen the types that hang around at the train station, I decided to take the plane instead, which disappointed the ticket seller at the train station greatly. Perhaps he was complicit with the scary types.

In Corumbá, I met three Australian girls outside my hotel. We arranged a tour to the Pantanal, the greatest wetland area in the world, with three Indians who drove us 100 km into the area.

When we arrived at the house where we should stay overnight, it had rained so much that we needed to wade through a swamp with water up to the knees. I hoped there would be no anacondas there. I took off my shoes and when I came ashore and set my bare foot on the sand, one of the Indians held me back and pointed with his finger in front of me. As I couldn’t see anything, I leaned forward. A snake was lying there that had the same colour as the sand, only half a metre long but one of Brazil’s most poisonous ones. I would have stepped on it if I had not been held back.

In moments like this you realise how vulnerable you are when you move around in the tropics. You should always be accompanied by a local person.

We were somewhat suspicious about the arrangement. Particularly because one of the Indians said he had lost the key to the house in the water, which we didn’t believe. It didn’t get any better when we came to the house and saw animal hides hanging outside, and one of the girls said: “What a perfect place for a murder!” I cannot remember how we got into the house but I assume it wasn’t locked. Anyhow, nothing happened to us. There were bats in the house but not of the blood sucking type.

The surprises weren’t over. After Pantanal, I went into Bolivia and found a hotel just across the border. The hall porter took me upstairs and wanted to lodge me in the most remote room there was, at the end of a long corridor and with a steel net covering the window so that I couldn’t escape if someone planned to rob me during the night. There was a heavily armed police officer outside the hotel but the police in South America are often corrupt and help the gangsters. So, I took no chances and went back to Brazil to sleep.

At the train station in Bolivia, they advised me to take the night train. But I had had enough of night trains after my experience in Tunesia. A tourist told me that they sold tickets to seats in a middle row that didn't exist. Welcome to South America!

Two tourists said they had taken a train in Bolivia that was 4-5 hours late, with no explanation why, and that it took them 24 hours to get to their destination, likely with the train stopping at every single cockcrow and horse manure.

People throw everything out the window from Bolivian trains, cardboard plates, beer cans, and left-over food, which is a shame as the nature is very beautiful.

In La Paz, 3.6 km above sea level, I got mountain sickness with headache, visual disturbances, and extreme fatigue. The first evening, I dined with two Peruvian girls, two Brazilians, an Italian and a man with a turban.

The Italian was very funny. He asked the turban why he was in Bolivia.

"I am Indian. I travel because I am Sikh!"

"If you are sick then why do you travel?"

"No, no, I am a Sikh."

"So, how many Hindus did you kill?"

"No kill Hindus, fight government."

When we looked at the menu card, the Sikh made big eyes when he saw they served hot dogs. And the Peruvian girls wanted to have coca-tea. He exclaimed:

"They eat hot dogs here? I no never drink alcohol, use cocaine, eat dogs or smoke!"

It was an unforgettable evening, as it continued like this. I have rarely laughed so much in my entire life, and when the Sikh didn't understand why we were laughing, we laughed even more.

I saw Lake Titicaca in Peru and headed for Machu Picchu, coming as far as Cusco. But I ran out of time and needed to go back to Rio to catch my return flight to Copenhagen.

What influenced me the most was the relaxed attitude people had to time. When I came home, I couldn't understand why people always seemed to be in a hurry. When you have waited for a half or a full day to continue your journey in South America, it cannot bother you if it takes five more minutes than usual to get home from work because of a traffic jam. But of course, it doesn't take long before you are again like all the others.

# 4 Early articles and doctoral thesis

My first article was in a newspaper. In 1982, I showed that Gallup's survey of the public's view of a strike among doctors was full of logical fallacies and misleading conclusions about doctors being greedy, having no concern for their patients.[56]

The truth was that 99% of the doctors had voted no to the new working conditions they were offered, as they would lead to poorer patient treatment and poorer education of doctors. But Gallup misleadingly asked if the doctors went on strike because they wanted higher salaries and better working conditions, or because of a concern for patients.

Another question was even worse: Was the main reason for the strike that the doctors were offered too poor working conditions and salaries or was it because the doctors demanded too much? This is like asking a man if he still beats his wife or if he has stopped beating her. There is no option that he never beat his wife, and no option that salaries didn't play a role for the strike. Gallup concluded that the doctors went on strike because they wanted higher salaries, which was totally false.

### *Calorius*, a new microorganism causing obesity?

When I first tried to publish in a medical journal, I submitted a satire, two years into my medical studies. The editor, Povl Riis, of our Danish medical journal, *Ugeskrift for Læger*, was interested and asked for a revision, but I wasn't sharp enough, so my article, *Betragtninger over Calorius sp*. (*Reflections on Calorius species*), was not published.

I argued that obesity might be caused by an unknown microorganism, which I named *Calorius* because long-term exposure protects people from freezing. People in frequent contact with other people are at increased risk of getting infected. Another risk factor is travelling, which often increases body weight, likely because the traveller is not immune to local variants of *Calorius*. I suggested *Calorius* was mainly transferred via alcohol and food.

Spontaneous remission is very rare, but the condition may improve when the patient comes home after a journey (microbial remediation).

The prognosis is a shorter lifespan, but on the other hand, infected people have a greater quality of life. Possible sequelae are caloriophobia and alcohol phobia.

Vaccination with a self-disciplinary vaccine has been tried but has only temporary effect. Unpleasant diets deficient in essential amino acids that are important for the reproduction of *Calorius* may have an effect, but the rebound effect is considerable. Exercise may work but requires a large dose for a long time and can cause injuries.

Philip Morris reported some effect of inhalation of smoke from the plant *Nicotiana tabacum*, which is likely because the smoke contains substances with antibiotic effects.

In our own studies, we did not see an effect of antibiotics in humans whereas we noticed an unexpected weight increase in pigs.

I made a mockery of the excessive number of medical journals by using names for my references such as *Le Journal de la Médicine Gastronomique*, *Southern Pacific Medical Opinion*, and *The Southerner's Weekly Discoveries*.

Six years later, we had a Christmas party at the Department of Infectious Diseases at Rigshospitalet with satirical songs about funny incidences at the department and humorous speeches. When I told my colleagues about my failed publication, our professor, Viggo Faber, stunned us. He was highly respected for his creative thinking, which a colleague had praised

with a sign on the door to the conference room: “Institute for Immunological Free Thinking.” Faber told us that my idea that obesity could be related to our intestinal flora was a good one that had research in support of it.

**Randomised trial of liquorice**

By the end of our medical studies, we were assigned to various hospitals in Copenhagen to do clinical work. Even though there were options much closer to home, I chose to go to Herlev Hospital because some outstanding doctors worked there. Professor Povl Riis was an icon in medical ethics and had an incredible memory. He didn’t use his dictaphone on his rounds. When finished, he made dictations for all the patients in the conference room. Chief physicians Henrik R Wulff and Bjørn Andersen conducted highly acclaimed courses in medical statistics. These three people were some of the brightest doctors I have ever known. Later, I became employed at their departments of medical and surgical gastroenterology.

Four years into my studies, we received a young woman with a very high blood pressure at Henrik’s department. Upon careful questioning, we found out that she had consumed a small bag of liquorice during a long car ride. Liquorice contains glycyrrhizin, metabolised to aldosterone, and can cause oedema, hypertension, headache, sodium retention and potassium depletion.

I looked up the research, which was mainly case reports. I wrote a protocol for a randomised trial and convinced the director of Haribo, the manufacturer of *Piratos*, that he should deliver the liquorice for free. We were 24 staff members including myself who ate half a bag or nothing for four weeks, and after a four-week wash-out period, we switched to the other option.

21 persons had side effects, and 4 dropped out: One had a weight increase of 2.2 kg in just five days despite reduced appetite but had pronounced oedemas in the face and hands; another got headache and oedemas; a third got headache; and the fourth got hot flushes, dizziness and heartburn, which came back on rechallenge.

I published the study in our medical journal just before Christmas in 1983[57] and came in the news telling people what they should do. It was my first appearance in the electronic media, and when I met with my fellow students, one exclaimed: “Here comes the radio doctor!” It was the first randomised trial ever of the clinical effects of liquorice intake in human volunteers, and even today, it is still the only one.

**Insulin antibodies and scientific misconduct**

When I became a doctor in June 1984, I got employed at Medical Department C at Bispebjerg Hospital where I had worked as a student for one month. This was a cultural shock for me. In the drug industry, the culture was one of supporting each other, but at a hospital department, you were virtually never praised for anything, only reprimanded brutally if there was a little thing you had forgotten during the night while you were totally overworked and exhausted and your main concern was to make the patients survive till the next morning.

The head of endocrinology, Jens Lyngsøe, suggested I did a doctoral thesis on insulin antibodies, which he had done himself. Oh no! I had worked so hard, studying and working at the same time, and now I was supposed to continue working hard.

I collected about 500 articles on the subject but couldn't make much sense of them, and Lyngsøe didn't help me. I tried to construct dose-response curves on the effect of insulin, but I realised it was a mess and that not all researchers had been entirely honest. I also started an insulin trial at the department and yet again with no help.

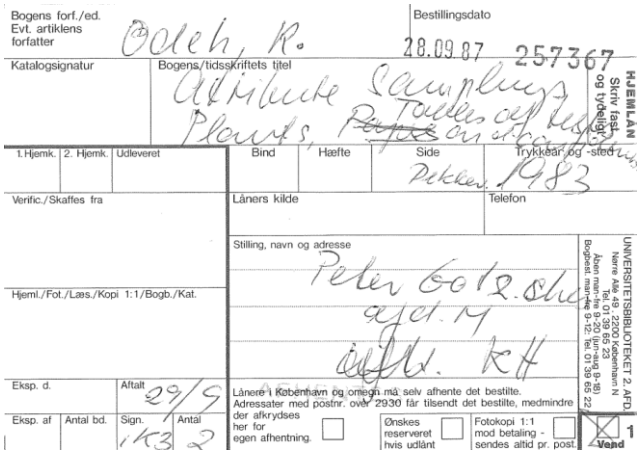
A year later, I studied the cardiovascular effects of insulin. I had worked out the insulin dose from a graph in *New England Journal of Medicine* and thought it wouldn't be possible for any of our diabetes patients to become overdosed. But the very first patient became hypoglycaemic to such an extent that I needed to give a rescue dose of intravenous glucose. When a colleague heard who the first author was of the paper I had trusted, an Italian named Geremia G Bolli, he told me that the graphs he published were too good to be true.

I published the study[58] but wasn't proud of it. It wasn't of any use. It had eight patients, but also eight authors, a bit much considering that only three people did the work. Doctors' attitude to authorship made one of my colleagues, Professor Daniel Andersen, remark that if a doctor had lent Shakespeare a pencil, he would have become co-author of *Macbeth*. There is also an amusing letter with the title *Et al. gets Nobel Prize*[59] (when there are many authors, it is customary to mention only the first few ones and the rest as "et al.").

**My doctoral thesis**

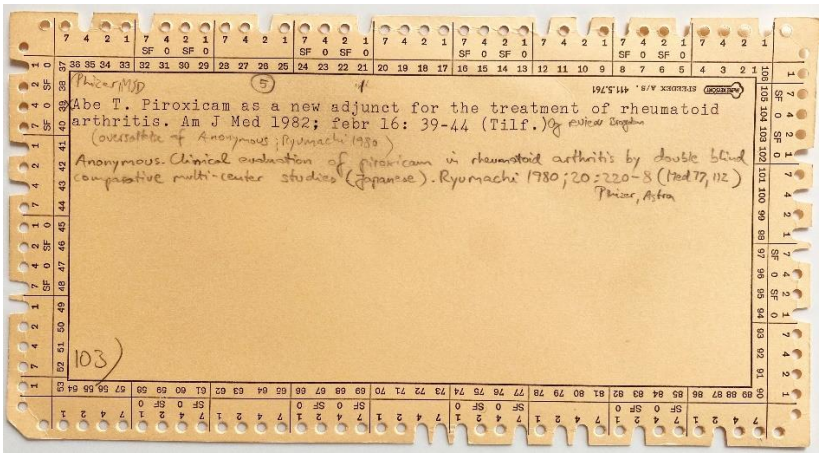
I dumped the 500 insulin papers in the rubbish and turned my negative experience into a positive one by making bias and fraud the subject for my thesis. I focused on statistical issues and read two heavy textbooks of statistics.[60] I ensured I had understood everything in them by repeating the mathematical proofs and by recalculating all the examples on a pocket calculator (I didn't get a computer before 1987).

In 1985, I wrote a protocol for my doctoral thesis and assembled 244 reports of trials that had compared one NSAID with another. Some of the trials had been published more than once. I wrote an order for every article I needed and sent it to the university library with the postman, hoping the librarian could read it (the example below wasn't filled in by me and I cannot read it):




I needed to go to the university library and collect the issues with the articles I needed. At Herlev Hospital, I became known as the doctor who occupied the photocopying machine, and I was often asked what I was doing. I worked with pen and paper and my typewriter.

And, as advised by Bjørn Andersen, I used punch cards for flagging the data I extracted from the articles:




I published six papers for my thesis, including one in *BMJ* and one in *The Lancet*, and a review of my work.[61] I worked alone, with no tutors or co-authors, to demonstrate I could do it myself. Darwin had no co-authors for his *On the origin of species*, and the famous physicist and Nobel Prize winner Richard Feynman also wanted his thesis to be his own.[62]

I only consulted a statistician once, when I needed a covariance term for a meta-analysis. I always check everything and found out the term was wrong, which another statistician confirmed and he provided me with the correct equation.[63]

When I had written the manuscript for the first paper, a senior registrar at the department where I worked became very interested and asked if he could see it. It was unique. I was the first person in the world to show that when authors quote similar trials in their trial report, they select positive studies more often than negative ones.[64] I called this new bias reference bias. The registrar provided some comments on the manuscript, and, to my big surprise, he asked if I did not think he should be co-author. I explained that I had done all the work myself and that my plan was to be sole author on all my thesis papers.

The following months were difficult, as the registrar harassed me. One day, we had lunch together with the chief of department. When the registrar complained that he had helped many young researchers without becoming a co-author, I had had enough. I slammed my wallet on the table and asked: “What is your hourly salary?” Nothing more was said, but the chief got my point and the registrar stopped harassing me.

Iain Chalmers, the founder of the Cochrane Collaboration, asked me to write a review about my discovery 35 years later.[65] Ironically, Dutch newcomers to the field gave their own findings illegitimate prominence by not citing my pioneering research in their review article, even though they could not have missed it in their searches. This was also reference bias.

It was the first time a whole therapeutic area had been so thoroughly investigated, and the examiners of my thesis - Ib Lorenzen and Henrik R Wulff, two of the brightest doctors in Denmark - got so shocked that they suggested that the bias and fraud I had revealed must be particularly common for arthritis drugs. This is not the case. What I demonstrated is the norm, for all drug groups.

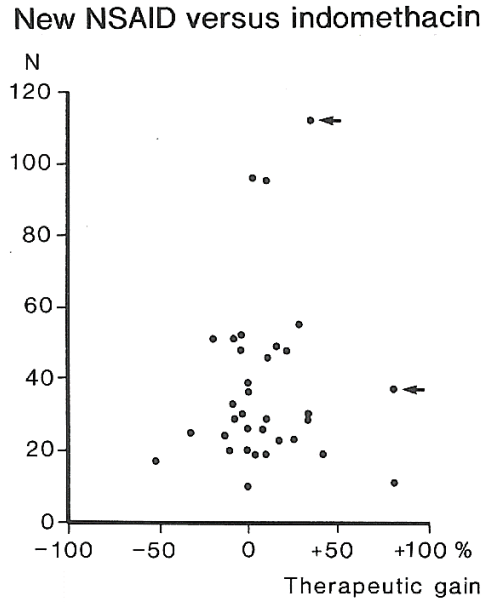
There were 196 head-to-head comparisons of NSAIDs, and I showed with statistical methods that the results couldn’t be true. The trials were very small, and they compared active drugs in a highly fluctuating disease, with a large interobserver variation. One would

therefore expect new drugs to have similar effects as old drugs and that, by chance, 2.5% of statistically significant differences would benefit new drugs, and 2.5% old drugs.

However, 14% of the differences were statistically significant, and in 73 trials, *all* differences favoured the new drug compared with only 8 trials favouring the control drug.[66] It was rarely possible to check the analyses, but I found 12 trials where the claimed statistically significant difference was wrong and 5 trials where I strongly suspected it. In *all* 17 cases, the false findings favoured the new drug. The results for side effects were even more striking. In *all* 39 trials with a significant difference, this difference favoured the new drug.

It is extremely unlikely that new drugs are both more effective and better tolerated than old drugs, and when I looked at the data instead of the P-values, the story changed completely. New drugs were not more effective than old drugs for grip strength,[67] the most common outcome.

The most important outcome when two NSAIDs are compared in crossover trials where the patients try both drugs is which drug the patients prefer. They are the best judges for weighing a certain pain relief against the harms. Most trials had used indomethacin, an old drug, as comparator, which, according to the industry, is particularly harmful. However, the patients preferred indomethacin equally often as a new NSAID.[68] Two trials showed an implausibly large benefit of the new drug (see arrows; their results lie outside the funnel shape of the other results):




The NSAID trials were untrustworthy marketing dressed up as science. The widespread manipulations were most pronounced for the conclusion or abstract, where the bias favoured the new drug in 81 reports and the control drug in only one report ($P = 3.4 \times 10^{-23}$). This was the lowest P-value ever reported at the time and I needed to explain to the editor how I had calculated it (easy: I used the binomial distribution).

My doctoral thesis became widely known. Just after I had defended it in 1990, biostatistician Douglas Altman found it and sent it to Iain Chalmers, the director of the National Perinatal Epidemiology Unit in Oxford, urging him to read it. I didn't know who Iain was, but that would soon change. He wrote to me, and when a French doctor, Jean-Pierre Boissel, invited Iain to a meeting in Lyon in April 1992, he ensured I was invited, too.

Boissel wanted to apply for funding for doing meta-analyses as part of an international collaboration, but I criticised that virtually all the money would go to himself while the rest of us would do the work, unpaid. The project never materialised. We sat in a meeting room at the uppermost level, just under the roof and it was a very hot day. The pigeons cooed outside the window and it became more and more intense, which made us stop talking and wonder what was going on. Then, Iain exclaimed: "Orgasm is approaching!"

## Co-founding the Cochrane Collaboration and its the first exciting years

Iain - later Sir Iain - profoundly changed my career and private life. He invited me to the British Minister of Health's opening of The Cochrane Centre in Oxford in November 1992 and paid for my travel. We had dinner at Balliol College where I was seated between two famous people, Sir Richard Peto and Sir Richard Doll, who showed that smoking British doctors die about ten years earlier than those who don't smoke.[69]

A year later, in October 1993, Iain gathered 77 people in Oxford who agreed to start the Cochrane Collaboration. The same month, Brian Haynes opened the Canadian Cochrane Center, Kay Dickersin opened the US Cochrane Center, and I opened the Nordic Cochrane Centre (at first called the Scandinavian Cochrane Centre).

We shared a frustration that we cannot trust the medical research literature and wanted to produce systematic reviews with statistical analyses (meta-analyses) of the randomised trials that could tell us what the benefits and harms are of our interventions. As randomised trials were often poorly indexed in databases and difficult to find, we embarked on a gigantic project where we hand searched medical journals, page by page, to find the trials and get them indexed in PubMed and other databases with a proper index term. Our work was supported by the European Union, and we published some of our findings.[70]

We published Cochrane reviews electronically so that they could be updated when new relevant trials appeared. The organisation is named after Scottish epidemiologist Archibald Cochrane who wrote in 1979 that "It is surely a great criticism of our profession that we have not organized a critical summary, by specialty or subspecialty, adapted periodically, of all relevant randomized controlled trials."[71]

Earlier, in the mid-1970s, Iain and his colleagues searched for randomised trials in obstetrics, which led to the publication of a massive two-volume book, *Effective Care in Pregnancy and Childbirth,* in 1989, a landmark in evidence-based healthcare. Cochrane praised this work and said it would be nice to see it applied to all of medicine.[72]

The founders of the Cochrane Collaboration included outstanding scientists, and in the following years, Cochrane continued to attract many bright and generous pioneers. It quickly became the most important organisation in the world that helps people make informed decisions about healthcare interventions.

What we achieved was outstanding. We didn't compete; we helped each other and our work was characterised by idealism, enthusiasm, no salaries, and collaboration.

I was a member of the Cochrane Steering Group from the beginning, from 1993 to 1996, which laid out the direction of travel for the organisation. This was stimulating work, very far from the enormous bureaucracy that was introduced twenty years later, which many of us believe killed the organisation (see chapter 14).

I loved my clinical work but told Iain that while I could only help one patient at a time as a clinician, I could help millions by doing a good review, which would be a better use of my resources. I also said that my career had gone from studying bugs in nature to studying bugs

in research. Like there are many different insects, there are also many ways in which research results can be distorted, and I have seen most of them.

When I tell people the truth, they might say I am rude, too direct, or that there is something wrong with my "tone." Sorry, but as a biologist, I have learned that when you see a bug, you call it a bug, not a butterfly. And when I see bugs in research, I describe them. This is my obligation as a scientist. Cochrane is highly dominated by British people and the rest of us sometimes have difficulties living up to British norms. The Brits might say, "That sounds interesting," when they really mean, "This is crap." Or they might say, "With all due respect," followed by a tremendous insult.

After the first meeting in Oxford in 1992, I contacted Christian Nissen, the managing director of the most prestigious hospital in Denmark, Rigshospitalet in Copenhagen. I told him about the UK Cochrane Centre and suggested to establish a centre at his hospital. When he said it would be better placed at the Danish Institute for Clinical Epidemiology, I replied that they didn't know much about meta-analyses of randomised trials and that it would be better to have the centre in a clinical environment. Nissen accepted this.

A year later, the hospital directors needed someone to help them with research and development. I applied for the post and got it. As it was the only royal hospital in Denmark, my employment at the management was confirmed in a letter signed by the Queen.

This job enabled me to work half-time as a Cochrane Centre director. Nissen got a little money from the Ministry of Health and offered some himself, a total of 230,000 crowns annually. This enabled me to employ a half-time secretary and to cover my travel expenses. But after three years, I was left to fend for myself.

In 2018, Nissen greeted us at the Nordic Cochrane Centre's 25th anniversary research meeting saying: "When Peter Gøtzsche crossed no man's land between the 14 floors and the now demolished red administration building in which I had an office, I had never heard of the Cochrane Collaboration. Whether it was Peter's description of the subject matter itself or his enthusiasm, I do not know. But he convinced me of the perspectives."

I had not yet become a specialist in internal medicine and wanted to complete my education. I had therefore agreed with the medical director, Hans Jørgen Buchardt Hansen, that a condition for my employment was that I would be allowed to pursue a part-time job as a clinician to accomplish this.

I did not get the agreement in writing, and whenever I took it up, Hansen was evasive. I therefore had no other choice than to go to his boss, Nissen. Nissen asked Hansen if it was correct that I had been promised a part-time leave, which Hansen confirmed. Then Nissen abruptly ended the meeting saying that Hansen must allow me that.

At the Department of Infectious Diseases, I shared a senior position for two years with Bente Klarlund Pedersen who also wanted to do research half-time.

I think Hansen felt humiliated and took revenge. We were often relocated within the hospital and on one occasion, Hansen moved us to offices where it was impossible for us to work. There was too little space, and it would be easy for burglars to break in and steal our equipment, which could be seen from the street through a huge window of the type you otherwise only see in shops.

We were devastated and sat on our boxes for some days, with no contact to the outside world, which had not been installed. I looked up the person responsible for all offices at the hospital, and we walked around on the premises until we found some rooms that were only used for courses now and then, which we got. I kept the furniture, which I badly needed.

This elicited a complaint from the centre that had used the offices, which was rejected with the remark that the centre director didn't own the furniture, the hospital did.

In 1996, I took over software development from the UK Cochrane Centre. Ever since, my centre has developed the software to make Cochrane reviews and other software of central importance to the organisation.

An important task for Cochrane centres was to convince governments to subscribe to the *Cochrane Library* with our reviews. I worked hard on this, and in 1998, the Danish Medical Association subscribed to the *Cochrane Library* for all Danish doctors.[73] In 2004, I announced that it could be consulted by all Danes via the Internet, free of charge.[74]

However, in 2007, the regions stopped co-financing the free access. The bureaucrats argued that the usage was low, less than 1000 views annually, from its own portal about health, sundhed.dk, but their tunnel vision was totally misleading. I noted in a newspaper that 39,163 Danes had downloaded a document the preceding year and that it is of fundamental importance for a democratic society that its citizens have access to information that is important for them.[75]

The Minister of Health, Lars Løkke Rasmussen, was urged by other politicians to provide the little money that was needed for free access, but he refused, even though full access didn't cost more than limited access for some health professionals. We received numerous complaints – also from doctors who could no longer get access via their computer.

I was told by higher-ups that I could not persuade the government to find the money. But I never give up if I have a good cause and after intense lobbying of politicians in Parliament, free access was financed again in 2009.[76]

I struggled to make my centre survive financially. I acquired funding for various research projects and my staff grew, but it became more and more difficult to sustain the infrastructure for important work that was not research. Moreover, if what you plan to do is threatening for the peer reviewers' vested interests, you can easily fail. I was often in that situation and none of my most important projects were ever funded.

We constantly hear that competition is good, and researchers spend an enormous amount of time writing funding applications. We all need to think carefully about what we want to do and why, but the funding system often stifles innovative ideas and impedes highly relevant research. The politicians' increasing interference with research, often in the form of earmarked research programmes, is also problematic. These initiatives are usually a huge waste of money and ignore that breakthroughs often require many years of investment, far beyond election periods and any imagination politicians have.

I have argued that it would be much more efficient to give top researchers a load of money, with no strings attached. I also noted that 90% of the funds from the Danish Medical Research Council went to basic research and only 10% to clinical or epidemiological research even though such research is much more likely to lead to benefits for the patients.[77] I suggested various reforms, including an evaluation of basic research to find out to which degree it has led to improvements for the patients.

My funding opportunities started to dry up in 1999. The only solution was to come on the government's budget. I was told it would be impossible, but one day, I said to the Ministry of Health that if they didn't provide basic funding for my centre, I would start dismantling it within the next six months and fire my key personnel. I would then conclude that, despite all the moral support I had received over the years, the Danish government

didn't feel our centre was important enough to fund it, and I would go back to internal medicine to become a professor.

You don't play poker with civil servants in high positions, they are too smart for that. The ministry realised I meant what I said, and two years later, the government provided permanent funding for my centre and the three Cochrane review groups I had helped establish in Denmark: the Hepato-Biliary, Colorectal Cancer, and Anaesthesia groups.

The funding matched the staff I had at the time, which was considerable. My centre was the biggest in the world, and it continued growing till it had a staff of 18 people. Over the years, I spent over 30 million crowns on Cochrane IT development, which I had no obligation to do but felt was a meaningful contribution. I also established associate Cochrane centres in Norway, Sweden, Finland, Poland and Russia. The Russian centre director found it a bit amusing to be accountable to little Denmark but that was how it was.

The governmental funding was a good investment. In 2010, Denmark ranked 6 in terms of review production per million inhabitants,[78] and three of my own reviews, on mammography screening, alpha-1 antitrypsin and general health checks, saved taxpayers over 500 million crowns annually for many years, about 100 times our annual budget. In all three cases, our findings were negative, had direct political consequences and threatened powerful interests. The Danish Association of the Pharmaceutical Industry and the Danish Cancer Society constantly tried to convince successive ministers of health that we should disappear.

I had a very good time as a Cochrane director but also more than my share of employees who did not perform as expected. Some turned out to be unqualified for the job despite having good credentials; some suffered from depression, serious anxiety, psychosis or megalomania; some were untrustworthy; some became pregnant again and again, which makes it difficult to do a PhD; and two people tried to dispose of me through a coup.

In the beginning, I was not a leader. I was a researcher and gave my employees a lot of freedom and influence on the decisions I made. This backfired in 2001. Monica Fisher, the chair of Cochrane's IT development worldwide, and statistician Ole Olsen conspired to overthrow me. Ole was dissatisfied that I could not offer him a higher salary, which my hospital would not allow me to do, but he succeeded nonetheless to convince his union representative that I was a poor leader that deserved to be kicked out.

When this escalated, the human resources department at the hospital intervened. They arranged for all three of us to see a psychologist, Allan Holmgren. They described him as being very expensive but also very good.

Indeed. Allan is superb. He created an atmosphere that made Monica and Ole talk freely. They were so convinced they would prevail that when he asked Ole if they had planned to overthrow me, he affirmed it. But the fact was that they did not have good arguments.

I wanted to fire them both, but the hospital convinced me I should fire only Ole. The final straw for the hospital was when he accused not only me but also the hospital management of behaving unprofessionally.

The hospital sent me on a management course where I learned the first day that a leader must take the leadership on himself. After this, I listened to what people had to say about difficult issues and made it clear that the final decision was mine alone.

The course leader gave us a difficult task that had no solution but allowed him to study our interactions while we discussed the options. He said I had a superb sense of timing. When we had discussed for a while, I summed up the options and cut through it all and made a conclusion. Not too early, and not too late, which would have caused frustrations.

It took me a while to forgive Monica, but it worked out. I even helped her when she came in trouble herself in relation to her leadership in the international IT department I had established in my centre where people of many different nationalities had come to work.

Henrik Wulff once told me that he never wanted to become chair of the department, as there are far too many frustrations involved. You might get fired, although you did nothing wrong but was highly successful, in the public interest. Several of my most outstanding colleagues were fired because they threatened people with vested interests, and this also happened to me, in 2018 (see page 404).

**Other ramifications of my thesis**

My thesis led to an invitation by statistician David Moher in Ottawa to attend a workshop in October 1993 to define criteria for scoring the reliability of randomised trials. After a few hours, US physician Thomas C Chalmers – who is not related to Iain - said it was futile to try to agree on a quality score for trials as it wouldn't work. We should rather focus on the various biases, one by one. We agreed and decided to produce a guideline for good reporting of trials that enables the readers to assess if they are reliable.

This was the start of a series of reporting guidelines. Over the years, I co-authored guidelines for good and transparent reporting of randomised trials (CONSORT), observational studies (STROBE), systematic reviews (PRISMA), and trial protocols (SPIRIT), which most top journals refer to in their instructions to authors. The various guidelines were later assembled at the Equator Network website.[79]

Because of my methodological expertise, I was one an editor in the Cochrane Methodology review group for 17 years, and I held two highly appreciated and well-attended workshops for Cochrane editors in 2001 and 2002 in Copenhagen.

Tom was one of the twentieth century's greatest medical thinkers.[80] He was familiar with my thesis, and I was honoured when he invited me to join him when he went back after the Ottawa meeting to his summer house in New Hampshire.

*On golden pond*, the 1981 movie with Henry and Jane Fonda and Katherine Hepburn that won three Academy Awards, was filmed there. There was a scene where someone looked down from the first floor, but as there was no first floor in the house, the filmmakers asked if they could build one, which was granted. The film was a huge success and Tom regretted he had not asked for a small share of the revenue.

Tom's summerhouse

Peter and Tom

Tom was known for his blinded wine tasting, and I tasted two different wines and couldn't tell which one was the most expensive. Years later, I did the same at a Christmas party for my staff. We tasted 10 different wines, rinsing our mouths with water after each test. Some wines cost three times as much as the cheapest one but the correlation between price and quality was exactly zero.

Tom died two years later of prostate cancer, but his legacy is huge. Early in his career, he said: "I really did not question the pearls of wisdom from the experts until I got into practice. At some point I said to myself, 'I've killed too many people.'"[81] His mantra was "randomise the first patient" when you are in doubt about which treatment is best.

A month before my visit at Tom's summerhouse, I attended my first peer review congress, in Chicago. It was the second such congress, arranged by an editor at *JAMA (Journal of the American Medical Association)*, Drummond Rennie, who became a close friend. I met with many editors of medical journals, including Fiona Godlee from the *BMJ*. When I told her how impressed I was with meeting all these interesting people, she replied that I belonged to the inner circle and deserved it. I was proud because this was only three years after I had defended my thesis but my name was already widely known. When the *BMJ* established an editorial board two years later, I became one of the members.

Henrik Wulff's book, *Rational diagnosis and treatment*, from 1976 was famous. I spent a few weeks at his department as a medical student, which made him aware of my great interest in research methodology, but I was highly surprised when he suggested in 1985 - when I had only published two uninteresting papers – that I updated the book with him.

I sent two draft chapters, but I was unexperienced and they were not well written. However, we continued to collaborate, and in 1997, we published his book together, in Danish.[82] Three years later, we updated the English version, and we published another update of the Danish version in 2006. Henrik was now 74 years old, and when I told him that we needed to update also the English original, he asked me to do it alone. So, the last time Henrik's wonderful book came out was in 2007.[83] It has appeared in nine languages.

Henrik was a giant. I met another giant in his home whose work I had studied intensely and learned a lot from: Alvan R Feinstein from Yale, considered the father of modern clinical epidemiology. People have said about Feinstein that, whenever he rose to ask a question during a conference, the lecturer became anxious because he was so sharp.

When Richard Smith, *BMJ's* editor, in 2013 wrote a foreword to my book about organised crime in the drug industry, he started out by saying something similar:[84]

"There must be plenty of people who shudder when they hear that Peter Gøtzsche will be speaking at a meeting or see his name on the contents list of a journal. He is like the young boy who not only could see that the emperor had no clothes but also said so. Most of us either cannot see that the emperor is naked or will not announce it when we see his nakedness, which is why we badly need people like Peter."

## Helle, my wife and my life

The by far most important outcome of my thesis was of a private nature. My colleague in Norway, Andrew Oxman, wrote poetically: "Meta-analysis gave Peter a life and a wife."

I held a PhD course in meta-analysis in April 1994, with Andy and Arne Ohlsson from Canada. A pretty, red-haired girl, Helle Krogh Johansen, was very interested, and on the second day, I wondered if her interest might be more than professional. But I had no idea about what to do and didn't want to do anything embarrassing.

We got to talking about her research during the breaks. I am sure nothing would have come out of it if Helle, when the course was over and we were packing our bags, had not asked me if it was possible to do a meta-analysis of two animal studies she had read. I was thrilled by this opening and asked her to send me the articles.

I looked her up in a register of doctors and found out she lived in Hørsholm. I also checked, in a thick telephone directory, if there was a man with the same phone number, which there wasn't. Just to be sure, I called the phone company and asked. Today, with our General Data Protection Regulation, this would not have been possible.

I waited impatiently for Helle's letter, which arrived two days later, on a Saturday, at 11 o'clock. Half an hour later I had read the articles, called Helle and said I would like to discuss them with her.

"When?"

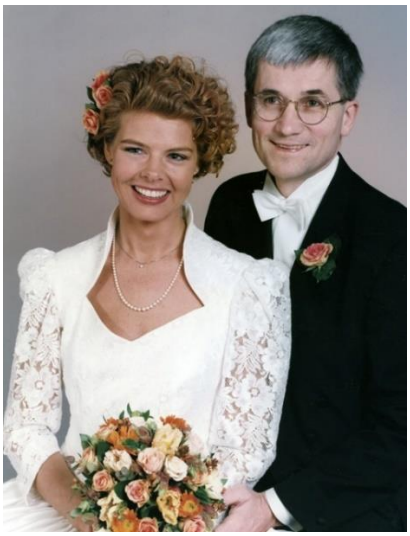
I've always been quick when I got the chance, so I cheerfully said, "I have time this afternoon."

Helle was impressed by my speed. Many years later she said that if I should have a tombstone, it should be engraved with: "He didn't waste his time," which I repeated in an interview 26 years later.[85]

Helle had been very formal. She had used the hospital's letterhead, and there was no private address or phone number in the letter. But she came the same day, in the late afternoon, to visit me in my house in Vedbæk, which was close by.

It didn't take long before our conversation and manners became private. I prepared a meal, and we covered a lot of ground during the evening, talking about past relationships and expectations for the future. Helle left at 1.30 in the morning and said she didn't have time to meet me again before five days later, despite the stormy start. I couldn't wait and sent her 10 long roses the next morning. This made her change her plans and I went to see her the same day.

Helle



Our wedding

Pernille and Ida in 2019

It took us just 24 hours to become lovers, and Helle, then 32, told her parents she had met the man she wanted to marry. "How long have you known him?" "Two weeks!" she said to their astonishment. My lawyer told me that a woman should not move into a man's house; she needs her own house. I sold my house, Helle sold hers, which was too small for a family,

and we bought one together, in Hørsholm. Four months later, she dropped the pill. We got two daughters, Pernille, who became a psychologist and Ida, who became a lawyer. They got my surname, which Helle didn't, as she was well known internationally for her research and didn't want to confuse people.

When Helle became pregnant, my main role was to protect her against ineffective or harmful interventions. Whenever a midwife or a doctor wanted to intervene, I consulted a book,[86] which was a short version of the two-volume book, *Effective Care in Pregnancy and Childbirth*, that Iain Chalmers and his colleagues published in 1989. After I had demonstrated several times to our mid-wife that what she wanted to do was not evidence-based, she became so interested that she bought the book.

Helle worked at Rigshospitalet as a clinical microbiologist and did research in cystic fibrosis. She had developed an animal model and defended her doctoral thesis in 1997. Later, her research in patients showed that her results in rats and mice could predict what would happen in humans. She became a professor and received a large grant from the Novo Nordisk Foundation, 60 million crowns, which involves a close collaboration with the Danish Technical University in Lyngby - one of the three best ones in the world, the other two being Chalmers in Göteborg and Massachusetts Institute of Technology in the USA.

Helle and I were quite amused when we were visited by one of Helle's relatives who documented that we are descendants of a famous Danish king, Gorm den Gamle, who ruled Denmark a thousand years ago. Even more amusing, Helle's relative had traced me all the way back to Adam and Eve. When my youngest daughter, Ida, once asked me, after a biblical lesson at school, who came before Adam and Eve, as they must also have had parents, I explained carefully about evolution and how humans had evolved from apes over millions of years. This made Ida ask: "Dad, have you also been an ape?" Well, yes. Not only been one. I am one. A naked ape.

Adultery is very common, which is why we cannot trust genealogical research. Genetic testing, e.g. because of a serious hereditary disease in the family or an organ transplant is needed, has revealed that 10% of children have another father than they think they have.

As this book is about my professional life, I shall just say about my private life that I regret I used so much time on my work. I am immensely grateful that I met wonderful Helle, got two wonderful children with her, and that we are still together. We have had our issues of course but that's life. My cousin, Michael Fibiger, said at our wedding that now the hard work begins!

Sports have always been very important for our family. Pernille and Ida became elite swimmers and won medals at the Danish championships. Today, Helle and I play golf and tennis and do weightlifting, and I also play badminton. Monday is my only day off.

Helle has run half marathons, which I found was a bit much. But when I lectured in Piteå in February 1972, I skied 25 km every afternoon, which was easy, and I therefore planned to participate in Vasaloppet, a 90 km track, which did not materialise, however.

# 5 The clinical years

I became a full-time researcher in 1997. Before that, I worked for 13 years at medical departments subspecialising in infectious diseases, rheumatology, gastroenterology, liver diseases, cardiology, endocrinology, and haematology, and at a department of gastrointestinal surgery, mainly at Rigshospitalet, but also at Bispebjerg, Herlev, and Hvidovre hospitals.

**Blood glucose was fine but the patients died**

In 1986, I diagnosed mild type 2 diabetes in an old man admitted for something else. I noted that it was common to prescribe tolbutamide, but since the only large trial ever performed was stopped prematurely because of an excess of cardiovascular deaths, and since those patients who took most of their daily doses also had the highest event rate, I decided not to institute treatment with tolbutamide.

My superior blew me up when he saw my notes: "How dare you not start tolbutamide in violation of the guidelines the endocrinologists have written?" I said calmly but firmly that I knew more about this drug than the endocrinologists because I had read the trial report carefully and the many articles and letters that followed, and a whole book about the issues.

The trial - the University Group Diabetes Project (UGDP) - was carried out independently of the drug industry, and it has been heavily debated and reanalysed. I have no doubt that those who were not corrupted by drug industry money were right.

Tolbutamide lowers blood glucose, but we treat patients to prevent complications to diabetes. It is therefore absurd that people used this drug when the only trial studying cardiovascular complications was stopped because the drug killed the patients.

It was particularly convincing that good compliers with tolbutamide had a greater mortality rate than poor compliers,[87] because patients who do what they are told are generally healthier than others and have better survival.[88]

Upjohn, the maker of tolbutamide, launched an aggressive campaign to discredit the UGDP study findings by using leading and corrupt academics, and the arguments became increasingly *ad hominem*.[89] They even sued the FDA to prevent it from mentioning the study's results in the package insert! Tolbutamide should have been withdrawn from the market, but as usual, nothing happened.

The next 40 years, the industry stopped performing trials that might have revealed that their drugs increase cardiovascular events, and our drug regulators let them get away with it. Rosiglitazone (Avandia), which also increased cardiovascular events, was taken off the market in Europe in 2010 after having killed thousands of patients. GlaxoSmithKline (GSK), the manufacturer, had touted that the drug had cardiovascular *benefits*! GSK kept trial results secret that showed that Avandia was harmful, bribed doctors to get them to use Avandia, and an expert who expressed concern about the harms, was threatened with legal action.[90] GSK's crimes made Avandia its most sold drug, even though the FDA knew that it increases LDL cholesterol and thrombotic heart events.

**AIDS trials**

I had only been a clinician for three years when, in 1987, I got appointed as chief at a newly established Nordic coordination office for AIDS trials at Rigshospitalet. I was busy with my thesis, and the job gave me more time for this, as I took a break of 17 months from my

clinical work. I also took a diploma course in tropical medicine, as my plan was to work for a while in the tropics. I kept the coordination job for eight years.

There was only one drug against AIDS, zidovudine. It was hugely expensive and caused serious harms. We therefore did a dose-response study, and I convinced my colleagues that we should go low and compare 400, 800 and 1200 mg in a blinded trial, and not 600 with 1200 mg as originally suggested. The manufacturer, Burroughs Wellcome, was vehemently against this and accused us of being unethical.

The real reason was that they would lose a lot of money, if the lowest dose proved to be the best one. Disappointingly, referring to the 400 mg dose, Professor Jens Ole Nielsen at Hvidovre Hospital refused to participate. I am convinced the long-standing animosity between him and Professor Peter Skinhøj at my department played a role. I just wanted to collaborate with everybody, but the Hvidovre people were unbelievably primitive. Chief physician Lars Mathiesen from Nielsen's department harassed me for no other reason than I was seen as "belonging" to Skinhøj's camp because I worked there. Later, I found out that some doctors from Hvidovre were on industry payroll, so this could also have been an issue when Nielsen sided with Burroughs Wellcome.

I had no role in these dog fights but Nielsen was also rude. When we met and I greeted him, he always pretended not to see me. I am rather sensitive to such behaviour because my stepfather also treated me as if I didn't exist.

The company forced us to buy the drugs at full price and made numerous obstacles. They sent supplies that would expire long before we could use them, so we broke the rules and gave the patients the drugs anyway. We were not on friendly terms with these people, and I hated when I had to talk to them. My contact in the company, Atle Wærsted, was particularly horrible. He was a doctor but had forgotten what medical ethics is about.

I wrote the protocol, designed the case report forms in the dBASE III programme, and monitored the study, which involved travelling in all five Nordic Countries. The trial was funded by the Nordic Medical Research councils, which refused to pay me in advance. I needed to use my private money for travel and everything else, which I got reimbursed with huge delays and sometimes only after a lot of trouble. It was highly unprofessional.

To avoid bias during data analysis and the writing of manuscripts for clinical trials, I had introduced blinding during curation and analysis of the data, and I even wrote the manuscripts blindly. This was so unique that I was invited to give a lecture about it, with all costs paid, at the annual meeting for the Society of Clinical Trials in Houston in 1994, which I published.[91] I wrote all manuscripts in two versions, and it was particularly interesting to write two discussion sections, not knowing what was A and B.

An example that it can be difficult to adhere to this principle was provided by a short-term, placebo-controlled pilot study of the effect of fusidic acid in African AIDS patients.[92] The P-value for the mortality difference was 0.06 with Fisher's exact test and 0.02 in a survival analysis. Despite the randomisation, there was a conspicuous difference in weight at baseline, and weight was strongly correlated with survival. Adjusting for weight yielded a P-value of 0.13.

During the discussions of the two blinded manuscripts, my co-authors suggested breaking the code to guide the analysis, but I refused. Under the null hypothesis of no difference in effect between drug and placebo, any decision taken during data analysis should be independent of the treatment code. Furthermore, the principle of blinding during data analysis and writing of manuscripts was specified in the trial protocol.

After both manuscripts had been accepted and the code was broken, I was again put

under pressure to make adjustments. When I refused, one of my co-authors produced a new manuscript with new analyses, some of which were clearly unwarranted and utterly hopeless, e.g. because some deaths that occurred after randomisation were excluded.

This led to heated disputes. I told my co-authors that if they went ahead with this, I would withdraw as author and would publish a letter to the editor explaining that they had violated the protocol. This convinced them to adhere to our protocol. The end of the story was that a second, larger study failed to confirm the nonsignificant tendency in the pilot trial. This trial was not published. In a way, all this mess was typical of medical research.

Statistician Hans Melander at the Swedish Drug Agency analysed our zidovudine data blindly and I wrote the manuscripts. The trial was highly successful. There were no differences in mortality or time to a new AIDS event, whereas the incidence of anaemia and leukopenia, time to first dose reduction, and numbers of patients withdrawn were all dose related.[93]

But the conclusion was awful: "Zidovudine should be limited to 400-600 mg daily in patients with AIDS or advanced HIV infection." Why on earth 600 mg? We had not even studied that dose. This was politics of the worst kind. I am convinced Jens Ole Nielsen played a role in this.

We had a grave suspicion that the first trial of zidovudine, published in *New England Journal of Medicine* in 1987,[94] had been manipulated by Burroughs Wellcome. They were "lucky" to stop the trial when the difference in mortality was greatest, 1 versus 19 deaths. Follow-up data, also for other trials, did not show anything near this dramatic effect. In fact, it turned out that zidovudine was pretty ineffective. I consider this another of the many frauds published in this prestigious journal.

We did another large AIDS trial in the Nordic countries, funded by Bristol-Myers Squibb. We demanded full academic freedom, and we did everything ourselves. When we had written the trial report, I went to the company's headquarters in Connecticut and showed them our results.[95] They never interfered with anything we did.

**Testing condoms in practice**

I was employed at the Department of Infectious Diseases at Rigshospitalet three times. One of the chief physicians called it Denmark's most exciting hospital department and he was right. It was very stimulating to work there, and I initiated several research projects.

One was a trial of condoms. The Board of Health talked a lot about safe sex during the AIDS epidemic and touted the use of condoms as safe sex. One of my colleagues, Ib Bygbjerg, jokingly said: "Just take a condom over your head and you will be safe."

I was sceptical. Condoms can slip off or break without you noticing it, and my own experiences were not encouraging. Those of us who were single and worked with AIDS therefore had the habit of testing ourselves and our partner for HIV when we started a new relationship.

I looked up the requirements for condoms. Four out of 300 could have holes in them and yet the batch would be approved. They were tested by blowing air into them. But what happens between two people is not blowing up condoms and use them as balloons, so I decided to test the condoms in practice. The department financed the buy, and I went to my local pharmacy and bought over 500 condoms, to the astonishment of the cashier. With my usual sense of humour, I should have said: "Just for the weekend!" but I abstained.

I contacted 39 female prostitutes who advertised in a newspaper and 28 people from the hospital of both sexes, and 30 prostitutes and 16 staff members agreed to test 10 condoms each by vaginal intercourse. One doctor who was single asked if I would also bring the girls, and a nurse burst into tears because her boyfriend had just left her. I did not ask more staff to participate after this.

The condom rupture rate was 5%.[96] Thus, it is a dangerous illusion to think that condoms provide safe sex. Even assuming a risk of HIV transmission of only 1% for unprotected sex, the probability that a partner to an HIV-positive person will become infected within 3 years, with sex 3 times a week using condoms, is 21%!

I was the first person in the world who tested condoms in practice. We sent our paper to *The Lancet* that rejected it, and before we got it published, two Dutch researchers published their results in *BMJ*, the same year as we did. They had tested condoms for anal sex in 17 males; 15% slipped off, and 11% ruptured.[97]

A year later, Bo Warming praised condoms in our medical journal. He claimed it was not known if they could slip off or rupture and noted that this had never been shown in studies where volunteers had been under observation. We replied that it was far-fetched to demand researchers at the bedside watching the erotic pleasures.[98] We also noted that people testing condoms had no incentive to lie to the researchers.

Warming argued it was feasible to study people having sex, which Masters and Johnson had done, and he suggested to use a robot. We replied that a robot couldn't possibly imitate all the variations in human mating behaviour.[99]

**Superfluous liver biopsies**

In the 1980s, there was a lot we didn't know about AIDS and the patients were tested excessively for co-infections. I decided to find out what the therapeutic consequences had been by sifting through the voluminous files for the first 33 deceased patients in our department. What we found was worth the effort.[100] Serum antibody titres were not important; blood, faeces, and sputum cultures gave a low yield; and the liver biopsies had been totally useless. Many doctors came from liver departments and were used to taking liver biopsies, which is why there were so many of them.

In 1989, when I worked at Henrik Wulff's department, he asked me to do a liver biopsy on a male alcoholic. When I asked why, he said that if the biopsy showed a fatty or cirrhotic liver, it might convince the patient to stop drinking.

I considered it unlikely that a biopsy could have such an impact and wondered if there was any evidence for this. Since a liver biopsy carries risks, I decided to adhere strictly to our national guidelines for informed consent, which means that the patient must be informed about possible harms, particularly if they are serious.

I began by saying the biopsy could be painful but that it would not be a major problem because we would give him a morphine-like drug. He immediately displayed anxiety.

Next, I said there might be bleeding in the stomach and that one in 200 patients requires blood transfusions. I had therefore ordered a few portions of blood, just in case. Now his anxiety was intense.

Finally, I told him that one in 5,000 patients die from a liver biopsy. Total silence. He did not ask a single question. It is 36 years ago, but I think I used these numbers.

I scheduled an appointment for the biopsy later the same day, but I never saw the man again. He made a quiet escape during lunch, and I felt I had done him a good service.

**You cannot kill head lice in your sauna**

My interest in insects led to a study I did in my sauna. I wanted to know if it was possible to eradicate head lice by raising the temperature and borrowed a thermometer at the Zoological Museum that could measure the temperature in the microenvironment.

The thermal death point for *Pediculus* is $46.5^0$ by an exposure of one hour, so there was a theoretical possibility of eradicating lice in a sauna. As there was nothing about this in the scientific literature, I carried on. While I raised the temperature in the sauna, the scalp inter-hair temperature went up from $30^0$ to $41.6^0$, which was the highest temperature I could tolerate.

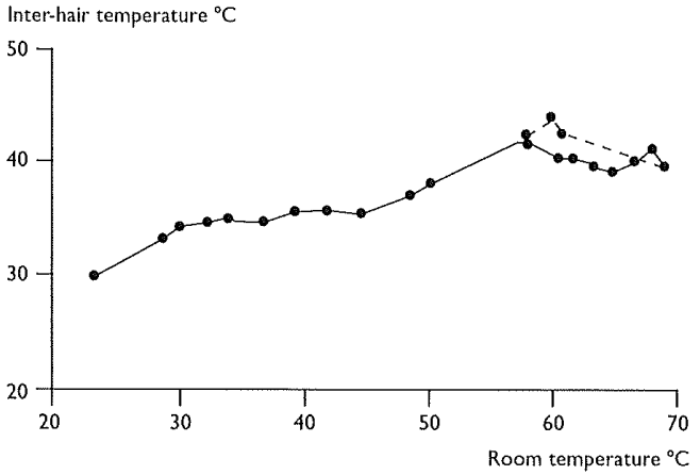



Fig. 1. *Scalp inter-hair and corresponding room temperatures in a sauna. The dotted line shows the temperatures after excessive water pouring on the hot stones.*

I published my negative result in our medical journal's Christmas issue[101] that contain papers written to amuse. For example, it was once documented that orthopaedic surgeons have bigger hands than other surgeons by measuring glove sizes. Another study showed that one-fifth of surgeons do not wash their hands after a toilet visit.

I noted that my study was remarkable because the convincing result was obtained without using patients (I did not have lice); it used the least possible sample size (one man); and the effect measure was a surrogate (temperature, rather than dead lice). I also noted that my study supported the often-recommended collaborative work across specialties, as I was both a doctor and a biologist. I concluded that the greatest use of private saunas was as storage rooms and that they were handy for hiding the Christmas presents, as people were unlikely to find them there.

Later, when our youngest daughter infected us with head lice she took home from her kindergarten, we removed the lice and the eggs with a comb.

My biological background led to an amusing incident when I passed the exam in dermatology during my medical studies. When I drew a question about lice, the examiner said that there are two species of human lice (apart from crab lice), *Pediculus capitis* and *Pediculus corporis*. I corrected her and said that they were subspecies of the same species, *Pediculus humanus*. My professor leaned forward in astonishment. And when I told them a lot about lice none of them expected a medical student to know about, he asked if I had participated in lice eradication campaigns, e.g. in refugee camps. I then revealed I was a biologist.

This reminded me of my exam in philosophy fifteen years earlier. I drew the question "Descartes" and started out by saying that his proof of God's existence was invalid. A provocative opening perhaps, but we had a good discussion about it.

**Disease-modifying drugs for rheumatoid arthritis**

In 1991, I did a meta-analysis of placebo-controlled trials of disease-modifying drugs in patients with rheumatoid arthritis and concluded that the effect was uncertain.[102] There was huge bias. The bigger the trial, the smaller the effect:

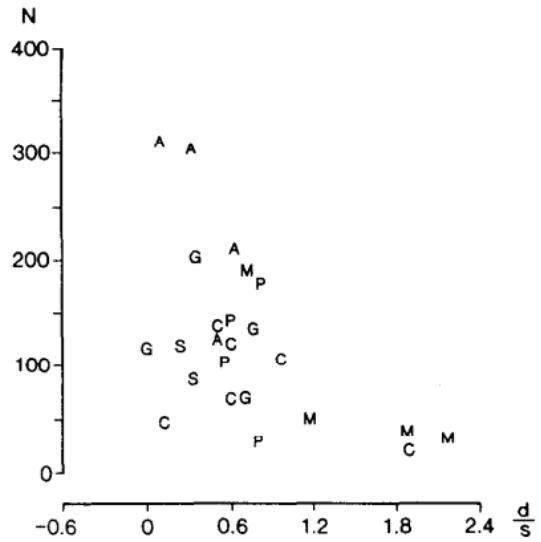



Fig. 1. Physician's global evaluation of the effect in relation to sample size: d/s is the difference between drug and placebo, divided by the pooled standard deviation; A—auranofin; C—chloroquine; G—gold; M—methotrexate; P—penicillamine; S—sulphasalazine.

Next, I wrote a protocol for a trial of withdrawal of these rather toxic agents to find out if the patients could tolerate to become switched to a placebo. It was a convincing study.[103] We included 112 patients in stable treatment with methotrexate, penicillamine, or sulfasalazine, and treatment failure occurred for 9 versus 33 patients (P = 0.000,001). The patients guessed their treatment correctly more often than expected (P = 0.02) because of the perceived effect whereas the observers did not guess better than chance. The budget for the trial was less than my salary for two weeks, and it was covered by the Arthritis Foundation. We got the placebos for free from the drug companies.

**Statistical expertise is very rare among doctors**

What I love about mathematics is that, in contrast to medicine, where you need to learn so much by heart, you can deduce what you need based on a few premises, and, if you are good at it, you won't be wrong.

Perhaps I should have become a mathematician. At the exam at the university, I drew a question, started writing in the upper left corner, and filled the whole greenboard with formulas, one derived from the other. The only comment from my examiners was: "Thank

you," and I got the highest mark available, which was only used in exceptional cases. Jokingly, we said you needed to know more than your teacher to get it.

If you are good at statistics and logic, you may shorten futile discussions - and get many enemies among all those who say, "I feel," "I think," "My clinical experience is ..."

Looking back, I should have chosen another science than medical research. I don't belong in an environment where truth is negotiable and corrupted by money.

By far most doctors are statistically and methodologically illiterate. A typical example is this statement: "In 58 cases (77.3%), the DSM-5 diagnosis of current mental disorder was not confirmed."[104] The percentage represents undue precision, as the 95% confidence interval is 68% to 84%. Thus, we are 95% sure that the true percentage is between 68% and 84%. The percentage should therefore have been given without a decimal, as 77%. Furthermore, no one can remember a number like 77.3%. It is easier to remember 77% and even easier to remember three-quarters.

The error of undue precision is very common. What is worse is that the lack of understanding of statistical issues leads to erroneous conclusions and mistreatment of patients.

I once explained in the *BMJ* that you can swallow your own words with a standard deviation.[105] The spontaneous talking time was 92 seconds (SD 105 seconds). Since the standard deviation is bigger than the mean, the statistical interpretation of this information is that a large proportion of the patients had negative talking times. The clinical interpretation would be, perhaps, that these patients swallowed unspoken words. The standard deviation has no meaning when the distribution of the data is not approximately Gaussian.

When I noted that new cancer drugs are not better than old ones, on average, oncologist Steen Rosthøj replied with a triumphant headline: *Half of new cancer treatments are better than old ones!* He did not understand what an average means. He might as well have focused on the other half.[106]

The world record in producing meaningless P-values might be in a trial comparing two NSAIDs.[107] The authors published 857 significance tests, and 48 were statistically significant, which is expected when there are no true differences (5% of 857 is 43). They even tested baseline data, which is misleading, as we already know - given adequate randomisation - that any differences must be chance findings.

I have often told colleagues to forget about statistics they don't understand and just look at the data. A study in the *BMJ* that received huge media attention claimed that suicide attempts in young people increased after the US drug agency had warned that depression drugs increase suicidal behaviour.[108] This made no sense because FDA's meta-analysis of these drugs had shown that they double the risk of suicide in young people. I noted that the authors had used complicated statistics with quadratic terms – which is extremely silly and untrustworthy - to make their point, and that we should look at the graphs instead.[109] They showed that poisonings and suicides continued to rise markedly in adolescents after usage of the pills started to increase again.

Because of my skills in statistics, I was invited to join several research projects where a statistician was needed. These projects included many studies in HIV infection and a study of weight loss on cimetidine, an anti-ulcer drug, which we carried out because we suspected - and were supported by the editor in this - that a positive result in *BMJ* was fraudulent. We didn't find any effect,[110] and the world didn't hear more about cimetidine for obesity.

I lectured with a professor in biostatistics who was impressed that I had done a three-way analysis of variance on my pocket calculator in relation to the cimetidine trial.[111] I had

needed to do this, as I did not buy a computer programme - which was expensive - until much later.

In 1995, I was the first person in the world to write a protocol for a trial, conduct the trial, and publish a trial report that also included a meta-analysis of all the trials, so that the readers received the most updated information about the treatment.[112] We compared a hormone, somatostatin, with placebo in patients with liver cirrhosis and bleeding oesophageal varices and showed the drug doesn't work.

**Introduction of health technology assessment in Denmark**

In 1996, the Danish Ethical Council asked me to write a report about the scientific basis and need for medical technology assessment. I gave examples of treatments that were not evidence-based and had harmed many patients, and of life-saving treatments that had not been used because no one had done a meta-analysis of the relevant trials.[113]

A year later, I shared a long taxi ride with the Minister of Health, Yvonne Herløv Andersen, which gave me an opportunity to discuss the possible introduction of health technology assessment in Denmark. She was very keen to do so and agreed that it was also important to fund my centre, as we were experts in evaluating the research literature critically. However, when an HTA agency was established, with an annual budget of 25 million crowns, a lot for a small country, we were forgotten.

As all my examples in the report to the Ethical Council were well documented, I was surprised by the strong and hostile reactions from some of my colleagues in leading positions, but I had trod on some sore toes.

I was heavily attacked by two haematologists, Niels Ebbe Hansen and Hans Karle.[114] They used the strawman argument that, in my universe, doctors behaved inappropriately and irresponsibly. They argued that doctors should be free to use undocumented treatments to save lives and believed that randomised trials could not replace, only supplement, the classical doctor role. However, it has been documented that this freedom has cost hundreds of thousands of lives. I replied that there is solid empirical evidence that randomised trials are a prerequisite for rational treatment of the individual patient.[115]

Hansen and Karle used the "eminence" trick in a most nauseating fashion. They claimed that several of my examples about medical errors had already raised objections from people or societies with "special insight in the conditions commented upon." I replied that medical history is full of doctors with "special insight" who, again and again, were mistaken.

When I worked at a department of haematology, I noted that the use of some drugs was inappropriate and highly expensive. One was antithrombin III, which cost 10,000 crowns per injection in 1991. There was no reliable evidence, and I discussed the issue with a specialist in coagulation disorders who agreed with me that the drug didn't work. But back then, it was not well received if you suggested that doctors who used very expensive treatments were corrupt, even though I knew this was often the case.

Two months later, I came under heavy fire from five specialist societies that published a joint statement,[116] and the two haematologists also came back. The correspondence ran over seven pages in our medical journal.

I was told that my report could be directly harmful. This provoked Henrik Wulff so much that he contributed to the debate:[117]

"In my naivety, I thought that all colleagues with a little critical sense agreed that good, randomised trials represent the ideal for documentation of the effect of new treatments,

and that we, as a general rule, should not start using new treatments before they have been tested this way ... Once a treatment has been introduced, it quickly becomes impossible to perform trials where a control group will not receive the treatment … I want to emphasise that Gøtzsche's views by and large agree with what we try to teach medical students in Theory of Medicine ... It is in the patients' interest, and not, as mentioned in the commentary, a strain on the doctor-patient relationship."

I rejected the arguments and provided additional evidence, e.g. that randomised trials had shown that new cancer treatments are not better than old ones, on average.[118] Thus, if we introduce new treatments without the necessary evidence, some will be worse than those we already use, but we will never find out which ones they are.

Many years later, when drug regulators lowered their standards so that new cancer drugs could be approved without a single randomised trial and with no data on mortality, Nikolai Brun from the Danish Drug Agency dismissed a criticism raised in *BMJ* saying that a survival benefit was not a relevant effect measure for cancer drugs![119] It is a serious problem that half of all new cancer drugs get approved without any documentation that they will benefit the patients.[120]

**Fraud in trials of antifungal agents**

In the mid-1990s, we were concerned at Rigshospitalet that cancer patients with neutropenia were treated with a hugely expensive antifungal drug, Ambisome, which drained our drug budget. I was critical towards the use of this drug and, as I was a member of the Drug Committee, I offered to look at this.

I did some Cochrane reviews of antifungals with Helle. We found out that this area had been totally corrupted by commercial incentives and fraudulent trials.

We reviewed the trials comparing Ambisome and other lipid soluble formulations of amphotericin B with conventional amphotericin B, which was off-patent and very cheap. The trials were rigged because the old drug had not been administered under optimal circumstances, with routine premedication to prevent infusion-related toxicity, and with fluid, potassium and magnesium to prevent nephrotoxicity.[121] We concluded that it was not clear whether there were any advantages of lipid-based formulations and that their high cost prohibited routine use.

Another popular drug was fluconazole sold by Pfizer, one of the most criminal drug companies in the world.[122] Pfizer had rigged a series of drug trials so that they favoured their drug. We published our revelations in *JAMA*,[123] which became frontpage news in *New York Times*.[124] Pfizer's fraud involved combining the results for amphotericin B with those for nystatin in a "polyene" group even though it was well known that nystatin is ineffective, which we confirmed in a meta-analysis of this drug.[125] Moreover, most of the patients who received amphotericin B did not get it intravenously but orally, even though it was known that it is poorly absorbed and should not be used this way.

It was also unclear if some patients were counted more than once. Some of the data were sliced and published several times, and the reports were obscure, but the primary investigators were unable to answer our questions and referred us to Pfizer that didn't answer them.

Despite repeated requests, neither the trial authors nor Pfizer provided us with separate data for the three arms in the rigged studies, and Pfizer didn't respond to our questions why they had used the two comparators the way they had.

Helle presented our results at a big international congress in Toronto in 1997 (ICAAC). The two chairs allowed many questions, extending her presentation by half an hour, which is unheard of at such a large meeting. The chairs had been involved with some of the rigged studies and they were thrilled that Pfizer's wrongdoing at long last was exposed publicly.

Pfizer also committed scientific misconduct in trials with voriconazole. There were two relevant trials for our review,[126] both published in *New England Journal of Medicine* in 2002 and both with misleading abstracts. No surprises there.

In one trial, voriconazole was significantly inferior to liposomal amphotericin B, but the paper concluded that voriconazole was a suitable alternative.[127] More patients died on voriconazole and a claimed significant reduction in "breakthrough" fungal infections disappeared when we included infections that had arbitrarily been excluded from analysis. The abstract described the flawed results for infections and claimed less nephrotoxicity, which was also incorrect. Pfizer reported the number of patients with a 1.5-fold increase in serum creatinine, but the convention is to report those with a 2-fold increase, which were the same (29 versus 32 patients).

The other trial handicapped amphotericin B by not requiring premedication to reduce infusion-related toxicity or substitution with electrolytes and fluid to reduce nephrotoxicity, although the planned duration of treatment was 84 days.[128] The abstract praised the drug highly, claiming a better response, improved survival and fewer severe side effects, but voriconazole was given for 77 days on average, and the comparator for only 10 days, which precludes a meaningful comparison.

By publishing such garbage, the *New England Journal of Medicine* earns a lot of money on selling reprints and it boosts the journal's impact factor,[129] which is the average number of citations of articles published in the last two years in the journal. In the first three years after publication, Pfizer's dishonest voriconazole trials were cited an astounding 192 and 344 times, respectively, much more than expected given the journal's impact factor, which was around 50 at the time.

We selected a random sample of 25 references to each trial and found that the unwarranted conclusions were uncritically propagated.[130] It was particularly disappointing - but expected as most papers were likely ghostwritten by Pfizer - that the FDA's relevant criticism of the analysis of the first trial was only quoted once, and that none of the articles mentioned the obvious flaws in the design of the second trial.

Helle and I did not find a survival benefit of antifungal agents given prophylactically or empirically to patients with cancer complicated by neutropenia, with the possible exception of amphotericin B.[131] We suggested that these agents be restricted to patients with proven infection. In an industry-sponsored meta-analysis of one of the drugs we had examined, itraconazole, the authors misrepresented our research totally and recommended itraconazole.[132] This was not supported by their data but was undoubtedly useful for the marketing department of Janssen, the manufacturer of itraconazole.

I don't think our research had any effect on treatment guidelines, as too many leading haematologists were corrupted by industry money.

**Fibiger's 1898 trial of diphtheria serum**

In 1998, the *BMJ* celebrated the 50th anniversary for the first randomised clinical trial, of streptomycin for tuberculosis.[133] I was one of the organisers and told Richard Smith that perhaps we should be celebrating the 100th anniversary because Johannes Fibiger from

Denmark published a trial of diphtheria serum in 1898. One of my PhD students, Asbjørn Hróbjartsson, gave a lecture about it, which we published in *BMJ*.[134]

Fibiger was the first to use random allocation and to emphasise it as a pivotal methodological principle. His vision, the many patients, and the rigorous planning, conduct, and reporting, makes his study a milestone in the history of clinical trials. The patients were allocated to serum or no serum according to the day of admittance, which created two very similar groups.

Fibiger was only 28 years old and a junior physician at Blegdamshospitalet in Copenhagen when he did the trial, and he did it all by himself and published the results as sole author,[135] which was remarkable.

Eight of the 239 patients in the serum group and 30 of 245 in the control group died. No formal statistical analysis was performed but "no objection can be raised against the statistical significance of the numbers," which were deemed correct by an inspector of the Disability Pension Association (two years later, Karl Pearson invented the chi-square test, which would have shown P = 0.0003). The rate of serum sickness was high though, at 60%.

Fibiger's results were immediately implemented, and the demand for serum increased so much that the State Serum Institute was built. However, Fibiger's methodological innovation had surprisingly little impact. The importance of random allocation was first fully recognised after the contributions of Ronald Fisher in 1925 in relation to agricultural experiments and Austin Bradford Hill in 1948 with his trial of streptomycin.

Fibiger received the Nobel Prize in 1927, six weeks before he died, for research indicating that a nematode, *Spiroptera carcinoma*, caused gastric cancer in rats. The hypothesis was later rejected but it had an important role in the development of experimental research on cancer. It is of particular interest to me, since so much of my scientific work has focused on randomised trials, that my mother was a Fibiger and that we are related to Johannes.[136]

Fibiger's ground-breaking research was published in Danish. During the discussion at the conference, an American said that "If the study hadn't been published in such an obscure language, we might have known about it." His insult was magnified by his horrible southern accent that underlined his disdain. I chaired the meeting and was so provoked by his cultural insensitivity that I said that, if the Vikings had stayed in Newfoundland, every person in North America might have been speaking Danish today.

**Unreliability of diagnostic tests**

During my clinical years, I noted that my colleagues had far too much confidence in the reliability of diagnostic tests. Whether the result was positive or negative, they trusted it. However, some results are indeterminate. This is also true for cancer, yet clinicians are almost always told that their patients either do or do not have cancer - not maybe. I once asked a pathologist why this was so, and he replied that clinicians cannot deal with uncertainty. They cannot act on a "maybe."

This black-and-white tradition has reinforced the false idea that diagnostic tests are accurate and unambiguous. Patients – and many doctors – do not realise that there is a continuum for almost all tests going from healthy people to very ill people, with a grey zone in the middle that can be quite large.

We must decide where to divide the grey zone. No matter where we make the split, some of those declared ill are healthy, and vice versa. And because we do not want to

overlook serious diseases like cancer, we tend to use the cancer label even for cell changes that are of doubtful significance and often disappear again without treatment.

If a patient had heartburn and a gastroscopy showed an ulcer, we accepted this and treated the patient. But how often was the diagnosis wrong? We will never know because there is no gold standard.

We can get an idea about it by letting two doctors do gastroscopies on the same patients independently of each other. In one such study, done by one of my colleagues, the doctors agreed there were no ulcers in most of the patients, and they agreed that 10 patients had an ulcer.[137] But in 14 cases, only one of them found ulcers. Thus, by having the patients examined by two doctors instead of one, the number of positive cases more than doubled. Ulcers are not as objective as people think. Scars resembling active ulcers might remain from previous ulcers, for instance.

Such discrepancies are common in clinical medicine and the observer variation when doctors examine the same patients is the basis for the saying that healthy people are those who have not been examined by enough doctors.

We did a study in Tanzania based on 200 serum samples from patients suspected of HIV infection.[138] Since the true HIV status was unknown, we could only do an observer variation study, in which we involved 5 observers and 5 HIV tests. Total agreement was reached for 111 of the 200 sera.

Sometimes new tests are introduced without much thought. An issue that bothered me when I was a hospital doctor was body temperature. Patients have their temperature taken every day because this can help diagnosing infections early when the potential for cure is greatest, and aid in monitoring if the antibiotic is working.

However, over 30 years ago, my hospital decided to discard the rectal mercury thermometers and use oral electronic thermometers instead. The arguments were better hygiene for the staff and no spilled mercury when thermometers broke.

I asked my superiors if there was any evidence that the new thermometers were equally reliable as the old ones. No one had investigated this, but even though they didn't believe so, my boss didn't protest when the hospital leaders, who were not clinicians, decided to introduce oral thermometers. They gave reproducible and accurate results when dipped into warm water, which was not reassuring, and in 1991, it was demonstrated that they were very unreliable in practice.[139] But it was too late to protest.

I raised the issue again when the oral thermometers were substituted by measurements in the ear. In 1998, one of the colleagues I had done research with finally did the study I had called for.[140] He compared an infrared tympanic thermometer with an electronic rectal thermometer in 121 patients admitted to a geriatric department, and 5% of the differences were larger than 1°C. This means that ear thermometers should not be used.

Eight years later, it was shown in a systematic review that infrared ear thermometry would fail to diagnose fever in one-third of children with rectal temperatures of 38°C or above.[141] Yet, nothing changed and Danish hospitals still use ear thermometers.

This story illustrates that we often fail to live up to the principles of evidence-based medicine. The issue about mercury is no longer relevant because we have rectal thermometers without mercury. Hospital acquired infections have been estimated to result in 99,000 annual deaths in the USA.[142] Considering the high death toll and all the hugely expensive high-tech equipment we have in our hospitals, not wishing to know the body temperature of our patients seems pretty insane to me.

**Don't lower the temperature when you have a fever**

Many people use paracetamol or aspirin when they have a fever. I learned from a colleague that this is a bad idea because the body's immune defense becomes ten times more effective if the body temperature is raised by a couple of degrees.

The fever response to an infection has been shaped through hundreds of millions of years of evolution.[143] The increase in body temperature is associated with improved survival and resolution of many infections. Conversely, the use of antipyretic drugs correlates with a 5% mortality increase in people with influenza and negatively affects patient outcomes in the intensive care unit.

If rabbits infected with rinderpest virus get aspirin, mortality also increases. Reptiles, fish and insects raise their core temperature during infection by seeking warmer environments despite the increased risk of predation, or, in the case of bees, by raising the temperature of the hive through increased physical activity.

In my household, we have never taken antipyretics when we had a fever. Don't do as US TV commercials say: "Ask your doctor if an antipyretic is right for you." Whether you are an insect, a reptile, or a human being, it is not right for you. Only if the body temperature is extremely high, can it be beneficial to lower it.

**Meningitis is being overlooked**

The most difficult thing about infections is to know when you should worry about them. Your doctor might not be worried but it is *your* life that is at stake, not your doctor's. The prime example of this is meningitis or meningococcal sepsis. Meningitis can be caused by bacteria, viruses and amoebae, but the most feared form is the one caused by meningococci (*Neisseria meningitidis*), which can also cause life-threatening sepsis.

Meningitis is a rare cause of death and permanent disablement, but it is easy to treat and it is unbearable when people die. Doctors should abstain from playing smart academics and instead allow the slightest doubt to benefit their patients. In a case, I was involved with, this didn't happen.

The patient was a four-year old boy admitted on suspicion of either bacterial or viral meningitis. A lumbar puncture is always taken, and the cerebrospinal fluid is analysed for cells, protein and glucose. Bacterial meningitis causes an influx of white blood cells and a reduction of glucose - a cell nutrient. However, distinguishing between bacterial and viral meningitis in this way is not always straightforward, particularly in the early stages when the differential count of the white blood cells can be atypical.

The doctor in charge decided to wait and see how the condition developed, because he felt the boy most likely had viral meningitis. I saw the situation very differently. I did not have children at the time but felt that if that cute little boy was mine, I would immediately give him a high dose of penicillin intravenously. I could not see any good reason for waiting since we had already drawn blood for culture of bacteria and had done a lumbar puncture.

This happened less than two years after I got my medical degree. The hospital system is highly hierarchical making it difficult for young doctors to argue with more experienced colleagues. I expressed my worries about postponing treatment but, as a young doctor, you need to accept what a senior colleague says.

My colleague's lack of empathy – which was also obvious when he harassed me when I was in charge of the Nordic AIDS trials - had tragic consequences. When meningococcal meningitis was no longer in doubt, it was too late. The boy died. I still reproach myself for not speaking out more loudly, even though I could hardly have changed my colleague's mind.

An even younger boy suddenly stopped breathing while I was in the room. Although there was a Ruben's balloon in every room to assist breathing, I instinctively rushed into action and blew air in the boy with the mouth-to-nose method. I don't know why he stopped breathing, but it turned out he also had meningitis and he recovered. For my part, I received a prophylactic antibiotic.

A third incident was equally heartbreaking as the first one. I was a senior doctor at the Department of Infectious Diseases and got a call from the emergency department. I was busy with acutely ill patients and the emergency department was so far away that I could not abandon my own patients. However, it wasn't necessary. I concluded on the phone that the patient, who was fully awake and felt very well but had small haemorrhages that were spreading in his skin, very likely had sepsis with meningococci. I told the junior doctor in no uncertain terms to give the patient 5 million units of penicillin intravenously immediately and explained why.

After a couple of hours, I had stabilised my own acutely ill patients and went to see the patient. I was deeply shocked. I was greeted by a man in his thirties with a big smile who looked forward to going home after we had taken care of his bleeding. My heart sank when I saw his skin and the large confluent haemorrhages. Despite my clear directions, the junior doctor had not started penicillin. I saw a happy, young man who didn't know he would be dead within a few hours.

The fact that the hierarchical system was respected in one case and not in the other resulted in the same tragic outcome. Infection with meningococci is a hyperacute emergency and a few minutes can be the difference between life and death.

About eight years ago, three young boys in Denmark aged 16 to 18 with meningitis died and the media asked why these deaths had not been avoided. The Patient Compensation Board concluded that they might all have survived if they had been treated adequately. I wrote about one of their stories, which made me think about what was wrong with our education and research priorities.[144]

One of the boys had classical symptoms of sepsis with meningococci and every doctor knows how important it is not to overlook this. Moreover, his mother suspected meningitis all along. To dismiss her concerns was unbelievably arrogant and stupid, especially when there was every reason *not* to do so. Her son was sent home from Herlev hospital, and when he returned a couple of hours later, it was too late.

Doctors do a lot of research. PubMed indexed 1.7 million papers and letters in 2023. This enormous productivity does not translate into much progress in patient care. Very few papers are of any use for diagnosing and treating patients. But in 2006, there was a remarkable exception.[145] The researchers assembled information about symptoms of meningococcal disease before the patients were admitted to hospital from questionnaires answered by parents and from data in primary-care records. They included 448 children, of which 103 had died. They found that the classic features of meningococcal disease - haemorrhagic rash, meningism (neck stiffness, intolerance to bright light and headaches), and impaired consciousness - developed late. In contrast, 72% of children had early symptoms of sepsis (leg

pains, cold hands and feet, and abnormal skin colour), which appeared 11 hours before the children were admitted to hospital.

Most children had only non-specific symptoms in the first 4-6 hours but were close to death by 24 hours, and only half of the children were sent to hospital after the first consultation. Therefore, all doctors must learn, again and again, that leg pains, cold hands and feet, and abnormal skin colour are signs of sepsis.

If your doctor does not want to start penicillin based on a suspicion of meningococcal disease, it will not help to shout. Say you will report the doctor to the hospital administration and to the Board of Health if anything untoward happens - and that you might contact journalists, too. And ask the doctor to repeat what he just said while you record it on your mobile phone (I say *he* because all the tragic cases I can remember involved a male doctor).

Why did it take so long before doctors studied which symptoms patients with meningococcal disease have? One symptom - neck stiffness - has been emphasised far too much and since it may not be present, many patients have died that could have been saved.

The way we prioritise research is wrong. This was succinctly stated by Doug Altman in a famous 1994 editorial:[146] *The scandal of poor medical research: We need less research, better research, and research done for the right reasons*.

Unfortunately, the research waste is still huge. If a science proposal is so complicated and high-tech that no one understands it, it is much easier to get it funded than if you wish your research to be useful for patients and doctors. Higher-ups forget why they became doctors. Or they ended up in high positions without patient contact because they were poor doctors.

Our medical education should be radically changed. I knew virtually everything about receptors and how drugs were supposed to work; could write the formulas for the 22 essential and non-essential amino acids; and could give the Latin or Greek names for countless anatomical structures and knew where they were located in the body. But what about those relatively few conditions that are often lethal if overlooked and curable if not? They must be hammered into the students' brains, again and again and again, in all possible ways, so that no doctor could possibly miss them.

**Having fun as a clinician**

I had a lot of fun when I was a clinician. Once, my job was to do a rectoscopy on a man admitted during the night. I found out he had pneumonia. The reason a rectoscopy was ordered was that the doctor on call had noted he had had a few loose stools. As this is not enough to justify a rectoscopy, I called the department to get the examination cancelled. Only the professor was available, and he said: "Can't you just do the rectoscopy, as the doctor on call has gone home?"

When the patient was lying in an embarrassing position on his back, ready for the rectoscopy, he said: "I am not a homosexual," to which I replied: "Neither am I, so you and I cannot make a couple!"

I dictated to his file that his rectum was normal: "The patient asked why he should have a rectoscopy. As the conversation was already humoristic, I replied: That's because you have pneumonia. He found that totally okay."

When I met the professor in the corridor soon after, he smiled. He must have seen my notes.

In medical files, we sometimes write, under general observations, that the patient appears younger or older than according to age. Once, two secretaries burst in laughter

when I came out of the examining room. I did not know why, so they showed me what I had dictated. Under Mammae, where you usually say there are no palpable tumours, I had dictated: “Appearance younger than according to age.” I did this because my patient had a rare hormonal disease and was treated with sex hormones. She was about 60 years of age, but her breasts looked like those of 20-year-olds. It was really astounding.

Being a doctor, you see and palpate thousands of breasts. This is routine, and only once was it difficult for me to be totally professional. A handball player showed up in the emergency room with a shoulder injury. I asked her to take off her sweater so that I could examine the shoulder. I had not expected that she had nothing under it and I almost forgot to breathe when I saw her breasts. She was incredibly beautiful all over, also in her face. We were alone, behind a curtain, and I – being single - was tempted to ask for her phone number but knew of course that this was out of the question. She also had an Italian name. Three mafia brothers might have come after me if I had asked.

Reaching the correct diagnosis can be difficult, but sometimes no aids are needed. When I worked as a rheumatologist, I saw a patient with pains everywhere. It did not make sense. So, after having listened to her story, my first question was: “How is your sex life?” Perhaps it was a little bold suddenly jumping into the most private aspects of her life, but her reaction was unmistakable. She burst into tears and was surprised that I had zeroed in on the sorest point in her life. We agreed that she did not need a rheumatologist. I did not examine her or order any tests. I just listened and asked a question, and she was happy about that even though I couldn’t assist her with her sex life.

One of my last patients before I left rheumatology and went back to infectious diseases was an old man with knee pain. It was the end of a tough day, and I was worn out. He looked accusingly at me, as if it was my fault that he had pains. “How is this possible, as I never had knee pain before?” he asked. I replied: “One day, you will die, and then you can also say: How is this possible, as I never died before?” My secretary stared at me in consternation.

I waited a few seconds and then he burst into laughter. He had worked in the harbour all his life, and such people don’t shy away from blunt jokes. As he still wanted an explanation, I told him that such troubles come with age. “Oh,” he said, “then I will go home and change my birth certificate!”

The Christmas parties and other parties at the departments where I worked were attractive. I often wrote songs with satirical texts about what had happened at the department, with illustrations, and I also wrote a play where a nurse and I were the actors. And, not to forget, many of us found girlfriends or coming spouses at these events.

Once, I arrived a little late to the party and as soon as the most beautiful nurse in the room saw me, she exclaimed, loudly: “Oh, it’s you, Peter! I didn’t recognise you with clothes on.” Of course, what confused her was that I was not wearing my white coat.

At another party, I was seated next to a nurse who didn’t like me. One night, she phoned me at 3 a.m. and said I should come and see the chest X-ray for an acutely admitted patient. I wanted to go back to sleep and replied it wasn’t necessary. “Why did you order the X-ray, if it wasn’t necessary?” I replied that if I didn’t, the chief physician would blame me the next morning for not having done that. I had only been a doctor for a month, and she was not used to a young doctor arguing with such authority.

At the party, I said that since we shared company, we might as well make the best of it, and I started with a joke.

“Why are so many doctors married to a nurse?”

“That’s because they don’t need to get out of bed when she changes the bedding!”

That didn't improve my standing. In my view, the joke illustrated that doctors are lazy, but the nurses around me got offended. They saw themselves as academics that did not do such jobs.

## Of mites and men: institutional corruption, fraud and Cochrane editorial misconduct

Some people with asthma are allergic to house dust mites, and many physical and chemical methods have been tried to eradicate the mites or reduce their occurrence. One of my researchers, Cecilia Hammarquist from Sweden, wanted to do a Cochrane review of the trials, which became a hilarious story illustrating that there are no limits to stupidity, dishonesty and corruption in healthcare.

None of the interventions had any effect,[147] but our results were not welcomed. When we submitted our review to the Cochrane Airways Group, its editor, Paul Jones, said he needed total certainty that our data extraction was correct. This was surprising. We had studied the trials carefully and were a strong team of people, including a lung specialist who had done more trials than anyone else.

Jones asked us to review all the trials again, and we even had to go to the group's office in London to work there while "consulting" the editorial staff, as it was called. We did not need any help from people who were less qualified than us, and the extra work was a total waste of time. It did not change our results, but delayed publication of our review considerably, which was intended.

I learned later that, in the meantime, an application for yet another trial, similar to many of those we had reviewed but much larger, had been granted public funding amounting to £728,678. If our review had been out, the trial would likely not have been funded.

This was institutional corruption in Cochrane.[148] And it became worse. After we had agreed on a version for publication in 1998, Jones secretly changed our abstract. We incidentally detected this and complained about it. Some years later, when we updated the review with new trials, Jones changed our abstract again - and again without our knowledge or permission. This was serious editorial misconduct.

Our conclusion was that the interventions "seem to be ineffective and cannot be recommended,[149] which Jones changed this into, "There is not enough evidence to show" that the interventions were effective. This was called "Reviewers' conclusions," which was false. And to say that "there is not enough evidence" suggests that if we could have included the large UK trial, we might have shown that the methods worked.

Jones committed fraud. We had shown, with narrow confidence intervals, that we could not have missed a worthwhile effect. In our most recent update of the review, from 2008, there is still no trace of an effect, and the large UK trial made no difference to our results whatsoever.[150] With my statistical background, I *knew* that this would be the case.

In 2007, the editor of *Allergy* had become so tired of specialists routinely turning a blind eye to our review when recommending useless interventions against mites that he asked us to publish it in his journal, which we did.[151] He was particularly concerned about the new asthma guidelines published by the US National Institutes of Health.[152] An editorial in *The Lancet* called them "rigorous and evidence-based," but we explained that this was not correct for the house dust mite recommendations.[153]

The guidelines filled 440 pages. An expert panel recommended mattress covers quoting an editorial, a non-systematic review, a before/after study with no control group, a study about rhinitis, and a study we excluded from our review because there were no data for patients who were allergic to mites. One study was irrelevant because it involved multiple interventions and allergens. What remained were five trials, which did not show an effect of mattress covers. In contrast, we had 26 trials of mattress encasings in our review.

The eminences said nothing about our review, which was widely known and had been published in the *BMJ* nine years earlier.[154] Amazingly, this garbage came from the NIH.

In our *Allergy* paper, we mentioned a 2008 consensus report written by expert teams from two European academies.[155] It listed impermeable mattress, pillow and quilt covers but forgot to say that they don't work. *JAMA* called the guidelines evidence-based, and one of the authors said: "We tried very hard to make these recommendations evidence-based and tried to avoid expert opinion as the basis for recommendations."[156]

I noted in a letter to *JAMA* that the experts had not tried hard enough because the three references offered in support of their recommendations were irrelevant. I also said that we found that the average effect of the interventions on the peak expiratory flow rate - the most common outcome in asthma trials - was exactly zero, with a very narrow confidence interval. *JAMA* refused to publish my letter. Institutional corruption yet again.

Patients have been lured into accepting highly expensive super-vacuum cleaners, mattress covers, obsessive cleaning, air filters and throwing out carpets.

We were so appalled that we did a study showing how misleading narrative reviews are. Inspired by John Steinbeck's novel, *Of mice and men,* we called our paper, *Of mites and men*.[157] We found that 90% of the 70 reviews we included recommended physical interventions, with a highly biased sample of references in support of this. The most quoted trial had only 7 patients per group; its significant result seemed to be erroneous; and it was not a clinical outcome. The recommendations were often based on non-randomised studies, and the most quoted study had only 10 patients per group but claimed very positive results. In contrast, we had 54 trials and 3002 patients in our review.

In 2013, a survey showed that most Italian paediatricians recommend mattress covers, weekly washings at high temperatures, special vacuum cleaners and removing carpets.[158] The authors presented unwarranted criticism of our review and concluded that the best strategy was to implement all preventive measures. They acknowledged that it is impossible to eradicate mites because they invade houses from the environment.[159] Yet, this had no impact on their recommendations.

I went on the Internet to see if it was equally bad elsewhere. The text from the famous Mayo Clinic in the USA was dishonest:[160] "When you minimize your exposure to dust mites, you can expect fewer or less severe allergic reactions." And the authors recommended even more futile interventions than the Italian doctors, with no references, which means no accountability.

The UK charity *Asthma + lung UK* also failed miserably.[161] It had similar recommendations as the Mayo Clinic and advised to "open your windows regularly." This will ensure that more mites will enter the house!

Paediatrician Jesper Brandt Andersen was highly critical when the Danish Appeals Board in 2009 overturned a decision about paying for a mattress cover for one of his patients. He called the decision grotesque and wrote an article about it in our medical journal.[162]

I replied that the Appeals Board based its decision on our Cochrane review after having obtained an opinion from the Board of Health, which continued to recommend mattress

covers and said it was in dialogue with "doctors with great expertise in this area."[163] In the Board's 94-page handbook on allergic disorders, there was no reference to our Cochrane review, only to a small Danish trial with 47 patients, which did not find any effect on the asthma symptoms. I noted that "doctors with great expertise," both at home and abroad, had now had 11 years to think about our review, but this had not changed anything.

My attempt at bringing a little reason into the debate angered Andersen who wrote a new article that was full of untenable arguments and misquotations. He even claimed that our Cochrane review was not evidence-based medicine![164]

The allergy "experts" were extremely dishonest, as they must have known that the interventions *cannot* work. The reduction in allergens that can be obtained is far too small to be effective, and there are lots of mites in the environment that continue coming into the house. In 2010, experts on mites said in an interview that encasing mattresses could not work and explained that there are extremely few mites in the mattress compared to the rest of the house.[165] One of them noted that wrapping the mattress in allergen-proof mattress covers can best be compared to emptying the Atlantic Ocean with a teaspoon.

However, in the same article, allergy specialist Holger Mosbech recommended mattress covers and tried to argue that there was something wrong with our Cochrane review. This was a logical fallacy because, if he was right, this would not prove that mattress covers are effective. In 2022, Mosbech recommended, on our official website for patients, to remove the carpets and use mattress covers.[166]

The Board of Health announced that they would look at the evidence again, not because of our Cochrane review, but because the Appeals Board had decided against them.

The Board said that there was no reason to change its advice about using mattress covers and "no need to doubt the Board of Health's professionalism, or to doubt that the Board uses the best possible evidence."[167]

What a joke. The Board never changed its recommendations. In 2018, they wrote that "improved asthma control may be achieved if house dust mite-reducing measures are used in the bedroom,"[168] quoting a 2015 guideline, which said that using allergen-proof mattress covers may reduce the patient's contact with mite allergens.[169] In 2023, the Board claimed that exposure to house dust mites can be significantly reduced.[170]

It is incredible that massive stupidity and dishonesty in healthcare is so common and just continues, despite overwhelming evidence that the beliefs are wrong. But I think I know why. What decides what gets used in healthcare can be spelled with five characters: POWER or MONEY, which is about the same.

# 6 Mammography screening: great hoax and great censorship

Mammography screening displays all the worst elements in science: flawed research, fraud, blatant lies, censorship, editorial misconduct, unwarranted retraction of an important article, constant harassment, threats of litigation, death threats, serious misinformation from the authorities, lack of informed consent, a gigantic waste of money, and abuse of academic positions to suppress unwelcome research. It can hardly be worse than this.

I wrote two books about it, in 2012 and 2024.[171] The first won the annual Prescrire Prize and I went to Paris to give a lecture, which I held in French because some of the politicians did not speak English. Two years earlier, I went to New York State and Canada with my family on holiday, and we visited Cornelia Baines, co-principal investigator of the Canadian National Breast Screening Study, and her husband Andrew in Toronto and stayed with them while Cornelia helped me with the English language in my book. They became dear friends.

Saving lives and breasts are the two main arguments for screening and they are both false. Ironically, this total war against common sense and decency, which has harmed women, has almost exclusively been conducted by hyperaggressive males.

The Danish Board of Health could not find its feet. In 1989, the Board issued a book recommending screening based on three trials. In 1994, additional trials had appeared that were less convincing, and a new thick report was undecided. Strangely, a third heavy report recommended screening in 1997, although no new results had been published.

In Sweden, screening had been carried out for 14 years when an article reported in 1999 that there had not been any visible effect of screening on breast cancer mortality.[172]

In Denmark, people were sceptical and we only had screening in Copenhagen and Fyn. Because of the disappointing results in Sweden, Ole Hartling from the Ethical Council in the Danish Medical Association raised concerns, which was at a tricky moment, because a voting about screening in Parliament was just five weeks away.

Ole's concerns had the effect that the Board of Health asked me to review the mammography screening trials. I knew very little about the subject but the Board had a problem, and when people had problems, they often came to me to get them solved.

When the hot potato had landed in my lap, my statistician, Ole Olsen, and I started working and became astonished when we saw how bad the trials were. We took a break with our other projects and finished our report in just four weeks, as it would have been futile to deliver it after the politicians had voted yes or no to screening.

We concluded that it was uncertain if screening does more good than harm and pointed out some grave errors in the Board of Health's 1997 report, which favoured screening.

The director of the Board, Einar Krag, tried to make our report non-existing. When he realised this wasn't possible, he manipulated it and deleted bits that criticised the Board or were essential for understanding the harms of screening. Worst of all, he ensured that the Minister of Health, who was against screening, was not informed about our report before it was too late, and the voting had already occurred.

To have come so close to the uppermost power circles in healthcare seeing how politics in matters of life and death are made was one of the biggest shocks in my career.

We kept quiet with what we knew. I had no funding for my centre and worked on getting it from the government. It would not be wise to be seen as "non-cooperative" with the Board of Health as the funding would likely come from the Ministry of Health.

But we had told a colleague about our troubles, which he leaked. Three days after the voting, Krag's manipulations became front-page news.[173] The journalist mentioned that the

Board was in possession of a report that doubted the effect of screening but had shelved it. She called her article: *The truth about health is unwelcome*.[174] The revelations caused a leading speaker on health in Parliament to talk of Machiavellian methods, and he asked who decided what politicians were entitled to know about.

The affair was greatly embarrassing for the Board. My original letter to the Board and Krag's manipulated one, which he forced me to sign as if I had written it, were reprinted in full length in the newspaper.

In Krag's view, Danes were not entitled to learn about our findings. My view was that the whole world should know about them. Ole and I submitted a paper to *The Lancet* less than four weeks after the Board had stonewalled our report, which was published six months later.[175] We explained why mammography screening cannot be justified, which ignited a fierce debate that lasted 12 years.

After we had delivered our report, the Board asked us to do a Cochrane review, which they funded under the assumption that we were independent scientists. But the Machiavellian methods continued. They tried hard to manipulate us so that we arrived at the "right" results - our academic freedom was constantly under attack.

At a meeting with the Board's breast cancer advisory group, we were told bluntly that the credibility of our centre would not be supported by our report, and we were urged to include surgical expertise. We were fed up with all the attempts at censoring our science, and I replied that we didn't need surgeons, as we were not going to operate on the breasts ourselves. When the issue of including appropriate experts came up again, I said we had learned how to read and didn't need help with this.

Cochrane also used Machiavellian methods. Jim Neilson, Cochrane Steering Group co-chair, opined that our *Lancet* review gave the impression that it was a Cochrane review.[176] This was silly. Obviously, our paper was not a Cochrane review, and it was not published in the *Cochrane Library*, but our address was stated in our paper, which is obligatory. What had happened was that some staunch screening advocates went ballistic about our results and complained to Cochrane without providing any arguments to justify their anger.

Cochrane committed serious editorial misconduct. It was the biggest scandal in Cochrane's history.[177] When we submitted our review, the Cochrane Breast Cancer group refused to let us include the major harms of screening, overdiagnosis and overtreatment, even though they had themselves approved these outcomes in the protocol they had published.

Earlier, *Lancet* had offered us to publish a research letter based on the Cochrane review, but we declined as there was too little space. However, as it was our duty towards the women and their relatives to publish the harms data, we contacted *Lancet* again. *Lancet's* editor, Richard Horton, worked fast and ensured that we published a research letter and the full review that included the harms in *Lancet*[178] and the stymied Cochrane review at the same time, in October 2001.

We had been under immense pressure from the Cochrane Breast Cancer group and did not take this decision lightly. We consulted with prominent figures in Cochrane who strongly recommended us to publish a full version in *Lancet*. My centre's Advisory Board supported us and Cochrane's founder, Iain Chalmers, said Cochrane needed to grow up.

Horton wrote a scathing editorial about the Cochrane process,[179] but the scandal continued. It took five years and repeated complaints to the Cochrane Publication Arbiter and the Steering Group before the Cochrane Breast Cancer group was finally forced to publish our harms data in an update of our review.

When letters arrived criticising our review, Horton alerted readers that big issues were at stake:[180]

"Some senior scientists have said to me that this debate should not be taking place in public. Screening mammography is, they argue, too important for women's health to have its image damaged by questioning the technique's efficacy and safety." He noted that, to avoid accusations of censorship, "let the scientists doing the review publish what they wish to say – it is, after all, their work ... That way … the public sees science as a truly collaborative process, in which differences of opinion are not only respected, but also welcomed."

So true, but it took Cochrane only eight years to abandon the idealistic principles it was based on when it started in 1993 and to introduce censorship.[181]

Our *Lancet* research letter was clearly not a Cochrane review, but I apologised to Neilson that – in my desperation - I had called it, *Cochrane review on screening for breast cancer with mammography*. It was merely an announcement that the long-awaited Cochrane review was now available - like a journalist might have described it in a headline. Ironically, the full *Lancet* review was more of a Cochrane review than the censored Cochrane review that lacked data on the most important harms of screening.

I have done a lot of research on mammography screening and in 2011, I sent my book about it to Wiley, Oxford University Press, and Penguin. They all turned it down. The editor at Radcliffe, Gillian Nineham, was interested but the marketing director did not think it would sell much. I went to London and persuaded her, and the book was published.[182]

Screening leads to substantial overdiagnosis, which I documented with my PhD student, Karsten Juhl Jørgensen.[183] It is the detection of cancers that would not have been found in someone's remaining lifetime without screening. As it is not possible to distinguish between dangerous and harmless cancers, they are all treated as if they were dangerous, which is the major harm of screening.

A special case is carcinoma in situ. These cell changes are not cancer and are rarely detected without screening, and most cases never become cancer. However, as they are often diffusely spread in the breast, the whole breast is removed similarly often as for invasive cancer. So, screening increases mastectomies and other types of surgery. Moreover, some healthy, overdiagnosed women will be killed by their treatment, e.g. radiotherapy and chemotherapy. This is one reason why breast cancer mortality is an unreliable outcome. We found that screening doesn't reduce total cancer mortality or deaths from any cause.[184] Screening doesn't work, and I have even demonstrated why screening *cannot* work.

Karsten and I showed in numerous papers that official announcements about screening, including invitations to screening, are highly misleading, and that most of the research literature is flawed. The result of this massive deception is that hundreds of millions of women have attended screening without knowing it doesn't work and could harm them. This disregard of the principles for informed consent and national laws is one of the biggest ethical scandals ever in healthcare.

In many cases, the manipulations used to arrive at politically acceptable results were egregious and must have been deliberate. I have seen many stunning acts of hocus pocus that would make any magician envious, but which constituted fraud.

We have pointed out the flaws many times, but to no avail. Criminals are difficult to resocialise. The perpetrators and their allies continued to deliberately make the same mistakes in article after article.

A typical example of the dishonesty is the reaction of the Swedish Board of Health to the disappointing results in Sweden. Its director and two professors from the Board noted that the 10-year survival of patients with breast cancer was better in those counties that started screening early than in those that started late. However, the purpose of screening is to find cancers earlier. When the clock starts earlier, it guarantees that the 10-year survival looks better even if screening doesn't lower breast cancer mortality. Counties starting early will also have more overdiagnosed cases of harmless cancers, and the 10-year survival for these women is 100%, unless they die from other causes.

This error is also seen in leading medical journals. We criticised a 2006 lead article in *New England Journal of Medicine*, which reported a 10-year survival approaching 90% if lung cancer was detected by screening CT scans.[185] The paper garnered considerable media attention, and some felt it provided a persuasive case for introducing lung cancer screening.

In 2008, a newspaper announced that the 5-year survival for breast cancer had risen from 60% to 80% in 30 years.[186] Although they knew better, spokespeople from the Danish Breast Cancer Group and the Danish Cancer Society claimed that this was due to better treatments and screening. No one explained that a 5-year survival rate over a 30-year horizon is extremely misleading. Because of greater breast cancer awareness, more people have their lumps checked, and the average size of the tumours fell from 33 mm to 24 mm during just 10 years.[187] This change occurred before screening started.

Survival after diagnosis has consistently been abused by cancer charities in their propaganda for screening, which made me end an article in our medical journal by asking: "Does the Cancer Society have no shame?"[188]

Another deplorable trick is to extrapolate far beyond the data using untenable assumptions. This way, the Danish Board of Health got the effect of screening on breast cancer mortality wrong in its 1997 report recommending screening by a factor of 10![189]

A third trick is to remove the most important harm - overdiagnosis - by impermissible statistical adjustments or by using complicated statistical models, or both.

A fourth trick is to claim a substantial effect of screening when there is none by ignoring that breast cancer mortality also went down without screening. Denmark is unique because we only had screening in 20% of the country for 17 years. We found that the decline in breast cancer mortality was a little higher in non-screened areas and in non-screened age groups than when women were screened.[190] Elsebeth Lynge, who was responsible for the Board of Health's grossly misleading 1997 report, published a study claiming a 25% effect of screening in Denmark. We described in our paper what was wrong with her study. She also claimed it is possible to screen without overdiagnosis, which is mathematically impossible and therefore a dishonest claim.[191]

A fifth trick is to compare breast cancer mortality before screening was introduced with breast cancer mortality in those who had their cancer detected at screening, which include all the healthy, overdiagnosed women who, by definition, cannot die from breast cancer because if they did, they would not be overdiagnosed. Everyone knows such methods are impermissible, but screening advocates have produced study after study claiming huge effects of screening, e.g. a 63% reduction in breast cancer mortality. Swedish researchers have even postulated that *all* breast cancer deaths can be avoided with screening.[192] If they continue their line of research for other diseases, they may find the recipe for eternal life.

A sixth trick is to report percentages only. Elsebeth Lynge used this trick to claim that screening decreases mastectomies. She stated that 13% of the patients had a breast-conserving operation before screening was introduced, and that 45% had such an operation

after screening was introduced.[193] This information is horribly dishonest. Imagine a town with a certain level of crime. You divide the crimes into serious and less serious ones. Over a period, the rate of serious crime increases by 20% and the rate of less serious crime increases by 40%. This is a development for the worse. But although there is *more* serious crime and *more* less serious crime, a fraudster would say that, as there are now *relatively* fewer cases of serious crime, the situation has improved.

A seventh trick, used if everything else fails, is lying. I have given many examples in my articles and books that researchers have lied about their own research and other research as well. And I have been exposed to blunt lies about what my research showed numerous times.

An eight trick, which my opponents used when they didn't have any arguments, is to accuse me of having made errors, but I don't make errors in my research, and they never demonstrated any.

A ninth trick is to propagate distasteful personal attacks in the form of empty, condemning rhetoric that is impossible to respond to because it is unspecific. Some examples:

"Pure misinformation," "serious statistical mistakes," "worthless piece of work," "nothing of substance," "total nonsense," "a crusade against screening," "the claim amounts to scientific libel and defamation of character," "totally undocumented," "grotesque," "inaccurate," "completely inaccurate," "wildly inaccurate," "scientifically unsound," "beset by elementary errors and fallacious assumptions," "atmosphere of hysteria," "scare campaign about mammography," and "highly selective in the statistics used."

Other, commonly used tricks are "everybody agrees;" "you're not one of us" (and therefore not qualified to say anything about screening); and the ultimate trump card, "you are killing my patients."

Perhaps the worst bit of all this is that most journalists are too dumb to understand the tricks even when you carefully explain them. They therefore act – paraphrasing Lenin - as the mammography industry's useful idiots, uncritically propagating all its propaganda.

A very early trial was the Swedish Two-County trial from 1985.[194] It didn't last long before other researchers suspected that the trial's primary investigator, radiologist László Tabár, had committed scientific misconduct. Later, other Swedish trialists discussed this possibility between themselves and conveyed their concerns to me.

There are two main reasons for the suspicion. First, the effect was large, a 31% reduction in mortality from breast cancer. Second, when the breast cancer mortality curves for the screened group and the control group started to separate after a few years, it was because breast cancer mortality in the control group went up. In the other trials, it was because the mortality in the screened group went down, as would be expected if screening worked.

There were other oddities. Compared to more recent trials that reported minor effects, the Two-County trial had used poor equipment, had long intervals between screens, used only one view mammography, and screened the control group early on.

Some science journalists were also sceptical. Pulitzer Prize winner John Crewdson from the *Chicago Tribune* visited me several times and worked tirelessly on this issue for some years. He said that what people do with taxpayers' money must be open to public scrutiny, and he beleaguered Tabár for several days until he got away with data sheets that described causes of death.[195] He showed them to me in 2002, and they looked highly suspicious.

But Crewdson never published anything. An insider wrote to me: "Tabár threatened to sue the *Chicago Tribune* if they wrote any more negative articles about him, saying that his

pockets were deeper than theirs and that he would use the best plaintiff attorney in the US - he must be a multimillionaire given all the teaching he does in the US." Indeed. Mammography screening had made Tabár very rich.

In one of Crewdson's incriminating articles, he noted that 750 women disappeared from published reports of the Kopparberg part of the trial after 1989. He also reported that an investigative journalist - Inger Atterstam from *Svenska Dagbladet* - had received anonymous phone calls with death threats and accusations that her articles were killing women.

Tabár threatened *BMJ* with litigation after we had written that we would probably never know what happened, as he had denied other researchers - even the other Swedish trialists - access to his data. This was correct but *BMJ* immediately deleted our statement, and a lengthy absurd correspondence between Tabár's American lawyer and *BMJ's* lawyer did not result in its reinstatement.[196] Afterwards, Tabár lied about it all, claiming that our statement was false. This is what dishonest bullies do. When they have done wrong, they threaten journals to make changes and then say the whistleblower was wrong.

Our closest collaborator in Norway, statistician and physician Per-Henrik Zahl, and his colleagues reported in 2001 that when they found that the tumour data in the Two-County trial were inconsistent, their requests for access to the data in the publicly funded trial were refused.[197]

In 2006, we were exposed to editorial misconduct in the *European Journal of Cancer*. We had shown that breast cancer cases and breast cancer deaths were missing in the Two-County trial. Our study was published on the journal's website but was quickly removed, without our knowledge, likely because Tabár had threatened with litigation. We published our study elsewhere[198] and described the editorial misconduct in *The Lancet*.[199]

This led Peter Dean from Finland, Tabár's mentor, to harass us and those who agreed with us in vitriolic letters he sent to over 150 influential people. He claimed that there were several factual errors in the comment we had published in *Lancet* about the editorial misconduct. There were none, but liars don't care that they lie. When Tabár claimed that screening decreased total mortality, and I explained he could not conclude this based on his study, he lied about the design of his study.[200] But later, he contradicted himself. The problem with lying is that sooner or later people usually contradict themselves.

Elsebeth Lynge was a politician disguised as a scientist. The university selected her as chair for the evaluation committee when Karsten submitted his doctoral thesis on mammography screening in 2010. As all three members had conflicts of interest, we complained about it, noting that Lynge had already denigrated Karsten's work in the media and that his work represented a serious criticism of her own research.

Lynge replied she was not conflicted, as did the other examiners, which the university accepted. We therefore wrote again, this time not only referring to the university's own rules - *No one can participate in the evaluation of a thesis in the presence of circumstances that may be suitable to raise doubt regarding the impartiality of that individual* - but also to the law of public administration. We cut in stone what we meant:

"Mammography screening is a controversial intervention and a major international political topic of dissent involving huge economic interests and career investments … Any researcher will naturally wish to defend their own work against criticism, and in this case, we are concerned that the examiners could be tempted to 'find an excuse' for rejecting the sub-

mitted thesis, as such a move could be used as a very effective political tool in the ongoing dispute."

The university accepted our appeal and appointed a new committee without conflicted members. Karsten became Doctor of Medical Science without further obstacles. The two examiners were very good, but a screening advocate, Jens Peter Garne, opposed *ex auditorio* for 45 minutes, which was very embarrassing for himself.[201] He showed a headline from a newspaper, *500 breasts are removed every year without reason*,[202] and tried to hold Karsten responsible for it. The article noted that we had calculated that, because of screening, 500 women had the whole breast or part of the breast removed, which was correct.

To discuss a headline in a tabloid newspaper at an academic defence was pathetic, considering also that Karsten had eight papers for his thesis, five of which were in the *BMJ*. He obtained a 3-year postdoctoral grant from the Danish Research Council and was one of only five young elite researchers in healthcare that year.

In 2007, we were awarded the first prize from the Society of Medical Writers, for our *BMJ* paper on the content of invitations to mammography screening.[203]

There are three other awards I have been particularly happy to receive in relation to my work on mammography screening, as they carry the names of great people: the Skrabanek Foundation Prize in Dublin in 2001; the Niels A Lassen Award in Copenhagen in 2001; and the Michael Berger Award in Düsseldorf in 2009.

Petr Skrabanek was a thinker. When he wrote a detailed and instructive review in *The Lancet* on breast screening in 1985,[204] he was accused of being an armchair scientist. He responded to the untruthful statements and added, "people who sit are not necessarily less often right than those who walk about: Einstein did no more than 'armchair' research."[205]

Niels A Lassen did research in physiology, but the chair of the award committee said the motivation for giving me the award was that, like Lassen, I challenged traditional beliefs and stuck to my findings under pressure, if I hadn't been proven wrong.

In 2011, Elsebeth Lynge abused her academic position to reject an excellent PhD thesis in Norway. The head of the Norwegian breast screening programme, Mette Kalager, had shown that screening had not worked in Norway and had led to substantial overdiagnosis. Mette became the victim of the worst abuse of an academic position I have ever witnessed.

Lynge was one of the examiners of her PhD thesis, which Mette was sceptical about but had accepted. This cost her dearly. Lynge rejected Mette's paper on overdiagnosis for no good reason and even demanded that all discussion of overdiagnosis should be deleted from the thesis. This had nothing to do with science but everything to do with politics. I had seen the paper as a peer reviewer. It was of much higher quality than Lynge's papers, and it was outrageous that she rejected it. It was later published in a prestigious journal, *Annals of Internal Medicine*.

Mette withdrew the paper and resubmitted her thesis, but to her great surprise, it was rejected by the same committee that had recommended her to withdraw it, and yet again, for no good reason, and in a reject letter with little scientific substance.

This horrific political censorship caused Mette's main tutor, Hans-Olov Adami from Harvard University and Karolinska Institutet, to write to the Dean of the Medical Faculty at the University of Oslo that "The quality of the evaluation committee's comments is astoundingly low with limited scientific substance and indeed an element of vested interests and biased views."

I became involved and sent a letter to the Rector and the Dean of the Medical Faculty noting that the circumstances surrounding the thesis were so extraordinary that I needed to

react. I accused the university of maladministration and Lynge of having abused her academic trust.

Oslo University broke many elementary rules in the way they handled the case, which I mentioned in my 11-page letter to the Rector and the Dean. It was so bad that even Lynge's two co-assessors complained to the university about its lack of professionalism, which was a clear case of maladministration.

Rector's reply to me was arrogant. He did not respond to any of my questions or concerns I had raised but merely wrote that "The handling of this case has been in agreement with current rules and academic principles." This, we call bullshit, which, according to philosopher Harry Franklin, comes close to lying,[206] and it was false. He also noted that I was not "part of the case," which I was. Adami had involved me, and it is a moral imperative for me to help when good people I know come in trouble because of evil people.

Many people were highly upset about the affair, and I was interviewed in several media, including the Oslo University newspaper that published the article, *Abused by the evaluation committee*.[207]

It was agreed to establish a new committee. Adami suggested me as chair, which the university rejected. They regarded me as conflicted because I disagreed scientifically with Lynge. This is an invalid argument. Scientists often disagree, with brings science forward.

Ultimately, Mette got her PhD, after 1.5 years of agony where she had involved lawyers and her union. She abandoned her post as head of the Norwegian mammography screening programme, as her own research had confirmed that screening is harmful.

When she changed her mind about screening, the punishment was harsh. People at the Norwegian Cancer Registry, where she worked, accused her of scientific misconduct, a groundless accusation that was rejected by the Norwegian Ombudsman.

Everything has its limits. After the endless debates with screening zealots and their accusations that *BMJ* had taken sides, its editors had finally had enough. In 2010, they asked "a highly trusted observer of preventive health strategies," Klim McPherson, to take a look.[208]

McPherson's paper was unusually frank.[209] He asked whether the time had come for a serious scientific rethink of the screening programme, and he asked how a programme of such importance could exist for so long with so many unanswered questions. He criticised devastatingly the faulty methods used by the screening advocates, and *BMJ's* editor, Fiona Godlee, was also critical.[210]

Fiona chaired an Evidence Live conference in Oxford in 2013 where I lectured on mammography screening, and she told the audience she didn't go to screening because of my research. This lecture is publicly available.[211]

The press covered McPherson's revelations extensively. The *Independent* published an editorial, and in an interview, Godlee said:[212]

"The screening lobby thinks the *BMJ* has got a bee in its bonnet about screening. That is not the case - we follow the evidence. The Danish team [from the Nordic Cochrane Centre] do good work which is very thorough and of good quality. It is fair to say that we have not had the same quality of submissions from the other side. We would be delighted if someone came forward with a robust defence of the screening programme - I don't think they have done that."

But then came the backlash. An official review of the trials by a so-called independent group was published in 2012 in *The Lancet*.[213] The review was a disaster, a whitewash used to

"carry on regardless." The Cancer Screening Empire had fought back, and we explained what was wrong with the report.[214] It was just *too* politically expedient. As they say in *BBC's Yes, Minister* series:

"The Prime Minister doesn't want the truth, he wants something he can tell Parliament."

There were serious errors, e.g. the authors did not acknowledge that breast cancer mortality is a flawed outcome. Worst of all, they didn't publish any data on all-cause mortality or all-cancer mortality.

Two years later, I met with one of the authors, my good friend Doug Altman, at the Preventing Overdiagnosis conference in Oxford. I asked him why he had co-authored a report that was so flawed, and he admitted he wasn't proud of it.

Doug died of colon cancer in 2018, aged 69. Like me, he was confused as a young man and didn't know what to do with his life but became one of the world's finest biostatisticians. My interest in statistics and research methodology had the effect that I published more papers with him, over 50, than with anyone else. His intellectual sharpness was extraordinary, and he agreed with my major criticisms of the disastrous 2012 *Lancet* report he co-authored, which included the lumping of reliable and unreliable studies.

What this illustrates is very depressing. It shows that psychological factors, group think and group pressure, may trump science, even for the most outstanding scientists.

I was devastated. I had devoted so much time for 15 years telling people the truth about mammography screening. I realised it was impossible to win the battle because those who lied had too much political backing and there were too many of them. I published very little about screening after this. A dishonest paper in *The Lancet* had killed any further debate.

The saying that there is none so blind as he or she who *will* not see,[215] crossed my mind. The science is clear. As mammography screening is harmful, it should be stopped.[216] The only remaining question is how long we shall wait before this happens? Haven't we waited long enough?

What is most important for all cancers is to prevent their occurrence. If women don't go to screening, they will reduce their risk of becoming a breast cancer patient by one third and their risk of losing a breast by one fourth.[217]

Lynge took revenge on me. After I had lectured on Theory of Medicine for 20 years at the university, she became the new course leader. My appointment was not renewed, and there was no letter thanking me for my contribution. Lynge has no style.

I contacted the leader of the university courses but there was nothing he could do. Lynge had visited him and showed him the many places in my book where I had criticised her research. He even had a copy of the book, with all the stickers, she had inserted. She was very agitated, he said. I complained to Lynge's boss but to no avail of course.

Universities are not the defenders of academic freedom they should be. It is taboo to criticise your colleagues' research publicly, especially if your criticism is correct and suggests that those you criticise are scientifically dishonest.

What a despicable person Lynge is.

I have published 36 papers in peer reviewed journals and 139 other articles about mammography screening. We showed that the natural course of many screen-detected invasive breast cancers is to spontaneously regress;[218] that screening did not reduce the incidence of advanced tumours in Denmark and therefore cannot work;[219] that it increases mastectomies markedly;[220] and that the information provided to the public is seriously misleading.[221]

We wrote a leaflet for women to help them decide if they should go to screening, which volunteers translated into 16 languages, including Chinese, Arabic, Russian, and Urdu.[222] It caused quite some work for me, as I needed to find someone who could back translate, which revealed important errors in the translation. Fiona Godlee called our paper about the misleading UK leaflet[223] one of her top 20 articles in the last 20 years.[224]

The only things we accomplished was delaying the introduction of screening in Denmark by several years and that some women skipped screening because of our research.

I updated our Cochrane review in 2006, 2009 and 2013.[225] Because many more deaths had been published in two of the trials, I updated the review again in January 2023, and a month later, Karsten had agreed with what I had found. The updated mortality data show even more clearly than before that mammography screening does not save lives. As I anticipated big problems with the ubiquitous Cochrane censorship, I published these data in May 2023 on my website in the public interest.[226]

My concerns were justified. After we had submitted our updated Cochrane review, it took six months before we got any feedback. The peer reviews we received - from 11 people, 8 of whom were from Cochrane - were excessive, with 91 separate points we needed to respond to. Cochrane had become extremely bureaucratic, slow and ineffective.

We submitted a revised version and in June 2024, we informed Liz Bickerdike, Senior Managing Editor, Central Editorial Service, that, given the rapidly evolving situation in this area where two major guideline groups (the US Preventive Services Task Force and the Canadian Task Force on Preventive Health Care) had issued conflicting recommendations within the past month, we found it very important for an informed debate that our updated review was made available to the public and to decision makers. We told her we had decided to upload the review, amended as per the review comments, to a preprint server.

Bickerdike was unhappy with this: “Cochrane does not currently have a specific preprint policy, and as such, we advise authors not to upload preprints of unpublished reviews to online preprint servers.”

We responded that several other updates of a Cochrane review had been prepublished, and we uploaded our review,[227] which was much appreciated outside Cochrane. During the first two days, over 50,000 people saw my tweet about the updated review. But Cochrane no longer work for the patients; they work for themselves and are navel-gazing.

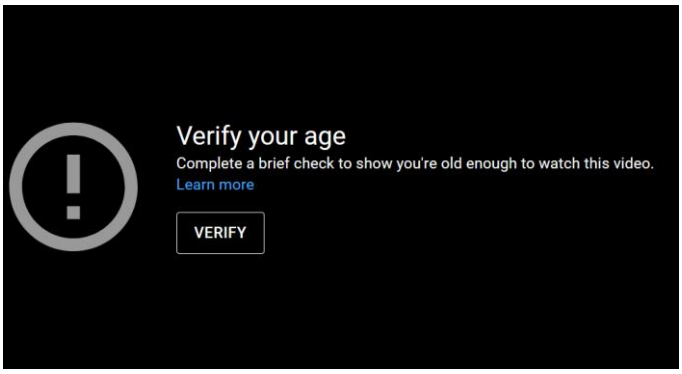
We thought there couldn’t be much more to discuss but had underestimated the Cochrane bureaucracy and censorship yet again. Three months later, we received 34 pages of comments, divided on 38 points and were told a major revision was needed, and that, if it was not accepted, the update would not be published, with no appeal. This was highly frustrating, also because some of the reviewers didn’t understand the basics of cancer screening but this didn’t prevent them from demanding ludicrous changes to our review.[228] For example, the editors required, with reference to the Cochrane Handbook,[229] that our statement "did not show a benefit in terms of a reduction in breast cancer mortality" should be "may show little or no difference in terms of a reduction in breast cancer mortality." We objected, as there was no statistically significant reduction in breast cancer mortality and as it is subjective whether a difference is small or not.

We were ignored, and our update was rejected in February 2025 for no good reason whatsoever. We were not allowed to call overdiagnosis for overdiagnosis or to present the results as they are even though everything we wrote was based on solid science and had appeared in earlier versions of the review. After several failed suicide attempts, Cochrane

finally succeeded committing suicide. The huge scandal in 2001 should have made the Cochrane leaders handle our update with care but they behaved like a bull in a china shop.

## The US horror of seeing a naked breast

Because of the increasing censorship on YouTube, I downloaded the most viewed videos of my lectures and interviews in 2021 so that I wouldn't lose them. It turned out that YouTube had blocked access to an interview at a book café in Barcelona in 2016, which made no sense.[230] Why? I embarked on an irritating journey. First, I was asked to verify my age to check if I was old enough to watch my own video:

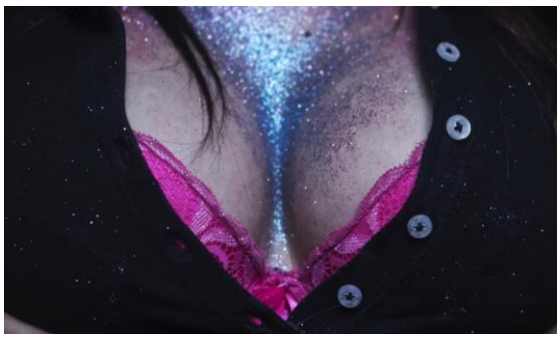



Is my age not private information? I could submit an image of my passport to Google.[231] No way. As passports are often abused to make fake passports, I never leave my passport at hotel receptions. I could also use my credit card, which I did.

Next, I needed to confirm that my date of birth matched my date of birth. Have you gone mad? How could it *not* match my date of birth? "Update date of birth," it said. Great! As I am quite old, I was tempted to wind the clock back some decades.

"Your ID will be securely stored, won't be made public and will be deleted after your date of birth is successfully verified." I don't trust social media the slightest bit when they say such things. As Google now knows how old I am, I might be exposed to ads for warm underwear, diapers for seniors, Viagra, statins, hearing aids, maybe even funeral services, just in case I won't make it for long. Google could easily do that even if they deleted my birthdate, e.g. by operating with age classes.

"You're all set. Thank you for confirming you're old enough to use certain Google products." But what were these products then? The opening picture was dull, but the next one was attractive for males:

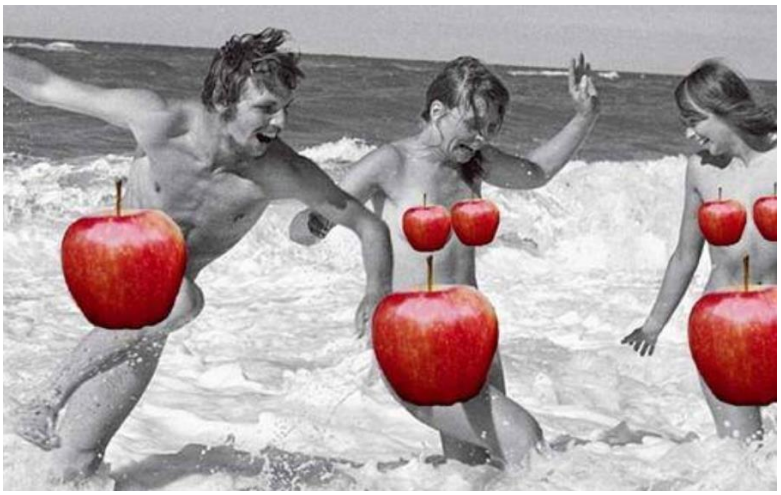
Four seconds later, a little video showed a breast being repositioned by a female helper to provide a better mammogram, and after the interview with me, there were two naked breasts, but you didn't need to be double as old to see *two* breasts instead of one:



I am vehemently opposed to the United States exporting its narrow-mindedness and fear of anything that might be even remotely related to sex to the whole world.

Please spare us American cultural imperialism and moral police on European soil. The US has a lot to learn from Europe about freedom and tolerance. Kenneth Schulz, a colleague from North Carolina, once told me that we Europeans had been very smart by getting rid of our worst religious fanatics who felt so unwelcome in Europe that they fled to the new world. He noted that the USA still suffers tremendously from religious fundamentalism, which another east coast colleague, Kay Dickersin, called the American Taliban.

In 2011, Peter Øvig Knudsen published, *Hippie*, a book about a Danish hippie camp established in 1970. When Apple demanded that he censor his book, which had 47 photos of naked people, he covered the genitals and breasts with apples:



The censored edition went on sale in Apple's iBookstore for only four days.[232] When Apple removed the book without offering any explanation, Peter asked if Apple would also ban apples to carry out their censorship. The publisher asked for a justification, but Apple didn't reply. Perhaps oranges would be more acceptable for Americans? Or a biblical fig leaf?

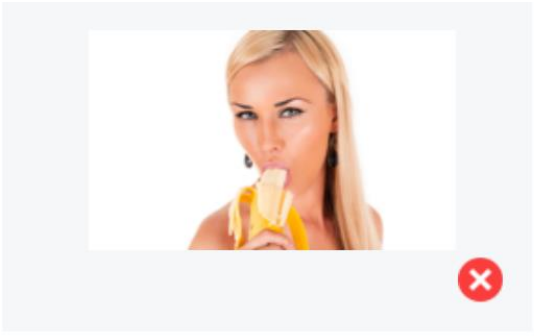
The photos are important for the book, as they illustrate what life was like in the camp. Nakedness was widespread. Here are a few more photos from the book:

This photo was much shared on Facebook:[233]

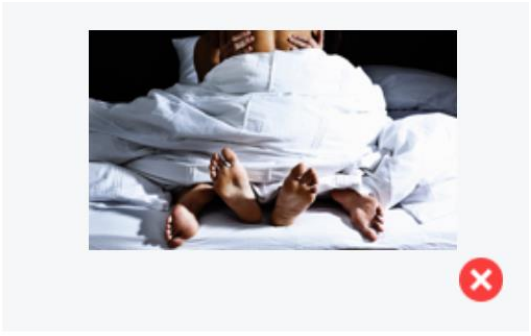

But Facebook's moral police deleted it every time and threatened to expel Peter[234] after he had posted the photos and mentioned Apple's censorship on his Facebook page. Google offered to sell his books without apples, but Google owns YouTube, which didn't allow me to see preparations for a mammogram. There is no consistency, and mothers have been furious that breastfeeding pictures of their newborns were removed by Facebook's nipple police.

In Denmark, we have a lot of freedom. In January 2011, Danish tax-payer-paid public TV had a theme evening entitled, *The cunt*. It had more viewers than ever before, even more than the golden moments in the European Song Contest.[235] In the USA, some people say "fuck" in every sentence, which is always replaced by a beep sound on TV, although everyone knows what was said. Why not show the world as it is?

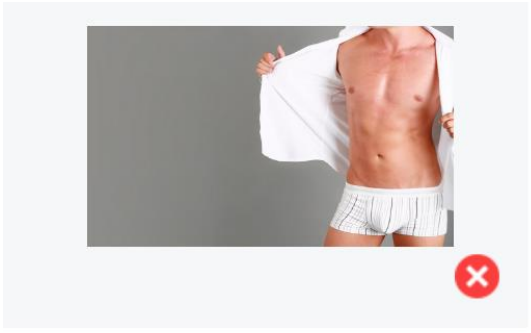
Facebook has even censored the Danish national symbol, *The Little Mermaid*,[236] because there is "too much visible skin or sexually suggestive content." Words cannot express my indignation. Facebook lives on another planet than mine. In January 2022, I found these photos in Facebook's guidelines:



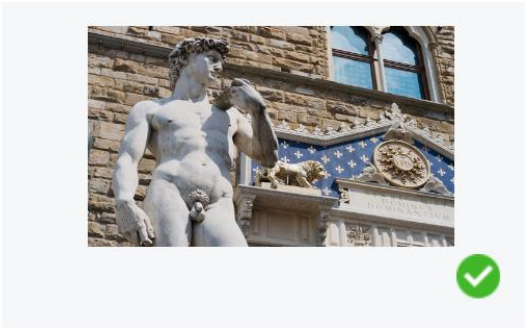
This image is sexually provocative and non-compliant.



This image alludes to sexual activity and is non-compliant.



This image is sexual in nature and non-compliant.

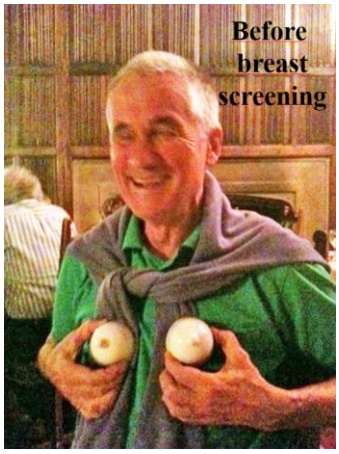


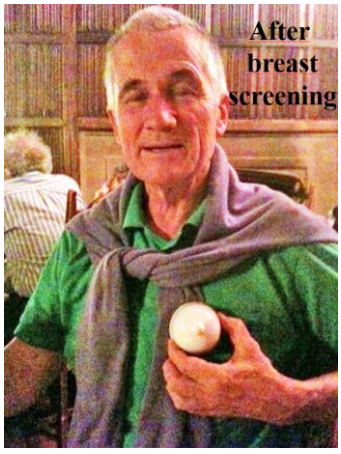
This image shows nudity in a statue and is compliant.

You'd better be careful when you eat a banana, that no one is filming you. You might be denied entry into the United States. The Little Mermaid was too sexy, but the statue is okay. So, it is better to look at one penis rather than two breasts, right? I think Facebook's nipple police consists of heterosexual males, as they are not aroused by penises.

As Americans are highly religious, I wonder what Facebook will do with all the old paintings of Adam and Eve where Eve shows a breast or two? Put oranges on them, as Big Tech is from California? Danish males, me included, are obsessed with breasts,[237] but I'd better keep quiet about this when I try to enter America.

Let's have a little laugh over these follies:




# 7 The truth about organised crime in the drug industry is taboo

When I decided to write about organised crime in the drug industry, I was met with closed doors in the publishing industry. I had not expected this, as the crimes were well-known. In 1984, criminologist John Braithwaite published the book, *Corporate crime in the pharmaceutical industry*.[238] After having examined the drug industry in great detail, and interviewed many top executives, whom he called ruthless bastards, he said:

"People who foster dependence on illicit drugs such as heroin are regarded as among the most unscrupulous pariahs of modern civilisation. In contrast, pushers of licit drugs tend to be viewed as altruistically motivated purveyors of a social good."

In 2007, I submitted a paper to *PLoS Medicine* about organised crime, academic corruption and lethal failures in drug regulation. The editor told me to rewrite it and asked if there was any specific reason why I wrote it.[239] I replied with a quote from *The constant gardener* by John le Carré:

"Name me the most secretive, duplicitous, mendacious, hypocritical bunch of corporate wide boys it's been my dubious pleasure to encounter."

"Defence," Justin suggested disingenuously.

"Wrong. Pharmaceutical. Beats Defence into a cocked hat."

One of the peer reviewers - *BMJ's* editor, Richard Smith - was very positive and hoped I would write a book. I once participated in a team with Richard investigating fraud in a trial from an Asian country.

The editor rejected my revised manuscript saying the risk of legal action was very high and that I would need to provide their lawyer with documentary proof that could stand up in a court of law. Well, everything I said had been published before, with no lawsuits.

Next, I submitted my paper to *Trials*, which rejected it after peer review.

Then I tried *Journal of General Internal Medicine*, as I had previously corresponded with the editor, G Caleb Alexander, about industry misconduct. He threw my paper out the window arguing that the tone was harsh and could put neutral readers off; that I had not compared drug companies with other industries; that I had not described industry's successes; and that I would need to expand considerably on my suggested reforms.

What Alexander wanted, was a totally different paper. He used a tactic that philosopher Arthur Schopenhauer described in his book, *The art of always being right*:[240] "If you are being worsted, you can make a diversion - that is, you can suddenly begin to talk of something else, as though it had a bearing on the matter in dispute and afforded an argument against your opponent … it is a piece of impudence if it has nothing to do with the case, and is only brought in by way of attacking your opponent."

If you document organised crime at length, you need not say that some of the gangsters are nice to their dog or help people in financial trouble. And the tone? This is a standard excuse editors use when they won't admit they rejected my paper because they don't want to disturb the interests the industry, powerful colleagues, or they themselves have.

When I published an article about the industry's crimes in a Polish medical journal in 2014,[241] Roman Jaeschke from the McMaster University in Canada didn't like my style either. I noted that two previous Editors-in-Chief at the *New England Journal of Medicine* respected my work and had used similar language, e.g. Jerome Kassirer wrote in this book, *On the take*, that he heard repeatedly from his colleagues that doctors who tour the country for drug firms, changing their talks to hawk the products of the sponsoring company, are called marketing whores.[242]

My fourth submission was to *Journal of Internal Medicine*, which rejected it without peer review for no other reason than not being of "sufficiently high priority." Of course. Good men don't want to hear that their views of the drug industry belong to the fantasy world.

I also tried *Journal of Law, Medicine & Ethics*, but they rejected my paper three months later. The editor didn't feel it added significantly new material to the already crowded field of pharmaceutical research. How dumb I was! People with an interest in law, medicine and ethics would not find a paper about law, medicine and ethics of interest if it disturbed their feeling good about law, medicine and ethics.

Next, I consulted a friend, clinical pharmacologist Andrew Herxheimer, who said that my paper was very important, strong, and properly relentless, and must definitely be published. Like Richard, Andrew also suggested I write a book.

Five years had now passed. In 2012, I submitted an improved version to *PLoS Medicine* again, *Corporate crime in the pharmaceutical industry*. It took the editors only 18 days to reject it. They were now concerned that the methods - Google searches on *fraud* and the names of each of the ten biggest companies, followed by a description of a prominent case from each company – might not provide a robust way of determining whether companies routinely break the law or if the fraud is deliberate, which would require further document analysis presumably using internal company documents to ascertain behaviour and motivations.

Of course. I got it. The economically highly lucrative and systematic fraud in all the big drug companies is not necessarily deliberate, it just happens out of the blue, right? And this Act of God – as it is amusingly called in UK insurance policies when a flood destroys your home, as if we still lived at the time of the Old Testament - by chance happens to result in gigantic incomes for the companies, right?

*Accountability in Research* is an attractive name considering the content of my paper. But a week later, I was told it was unacceptable because it was written in a journalistic fashion with claims way beyond a scholarly paper. They found the topic very important and noted that no one had written about it in a comprehensive manner to bring all of the misdeeds in one source. But I "confused crimes with allegations or reported misdeeds."

I see. So, all the ruthless bastards at the top are innocent although their companies settled or were fined billions of dollars. I was told to drastically shorten the paper or base it on much additional research and documentation. The editor, Adil E Shamoo, would not allow me to call a spade for a spade and provided examples of my overblown language: "Thus, there can be no doubt that the crimes are widespread and repetitive, which means they are committed deliberately. We are therefore not dealing with a lone bad apple but with a whole industry that is rotten, as it routinely breaks the law … My own study indicates that big pharma equals big fraud and big crime … what we are seeing is organised crime."

I then tried *BMJ Open*, which told me the same day that "this rejection is not for legal reasons. *BMJ Open* only publishes research papers and this article is much more of an opinion or debate piece, with an elementary Google search in support." I wondered what else I could have done than a Google search, which had been very helpful.

They suggested *BMJ*. To my big surprise, as *BMJ* is a much more prestigious journal than *BMJ Open*, my five-year Odyssey was over. My paper, *Big Pharma often commits corporate crime, and this must be stopped*, was accepted without peer review and published in 2012.[243] Four months earlier, *PLoS Medicine* had questioned if the fraud was deliberate. But *BMJ* respected my freedom of speech and allowed me to say that the crimes were likely committed deliberately - because crime pays – and that doctors are often complicit.

I advised tough sanctions, with fines so large that companies risk going bankrupt and jail sentences for the criminal top executives. And doctors and their organisations should recognise that it is unethical to receive money that has been earned in part through crimes that have harmed the people whose interests doctors are expected to take care of.

This is the only time in my career that I needed to try nine medical journals before I was allowed to tell the truth.

A year later, I no longer needed to use the euphemistic term corporate crime. I published the book, *Deadly medicines and organised crime: How big pharma has corrupted healthcare*, where I document that the business model of the ten biggest drug companies is organised crime that kill millions of patients.[244]

In the USA, Big Pharma beats all other industries in terms of serious crimes. I therefore prefer to call them the crime industry. The most common offences are illegal marketing of drugs for off-label uses, scientific misconduct, hiding data on lethal harms, defrauding drug providers (Medicaid and Medicare), bribery, kickbacks, large-scale corruption of doctors, obstruction of justice, violation of antitrust laws, conspiracies, and patent fraud.

I asked Richard Smith and Drummond Rennie if they would write a foreword, which they did. Richard emphasised that I was one of few people criticising mammography screening and that, despite intense, bitter and hostile attacks, I stood my ground and was proven largely right. He was shocked to read in my book on mammography how scientists had distorted the evidence to support their beliefs. He considered me an epidemiologist with very high numerical literacy and a passion for detail, which makes me a world leader in critiquing clinical studies surpassing all other critics by comparing the industry with organised crime.

Drummond wrote about my unique scientific abilities, research, integrity, truthfulness, and courage, and unequalled experience with a deep understanding of statistics and bias, being often annoyingly persistent but always driven by the evidence. I had proposals and called for a revolution. If I was angry at the behaviour of academia and industry, I had a right to be, and what's needed is more of my evidence-based outrage.

It is interesting to compare Drummond's view of me with all the industry-apologetic editors that constantly said there was something wrong with my tone.

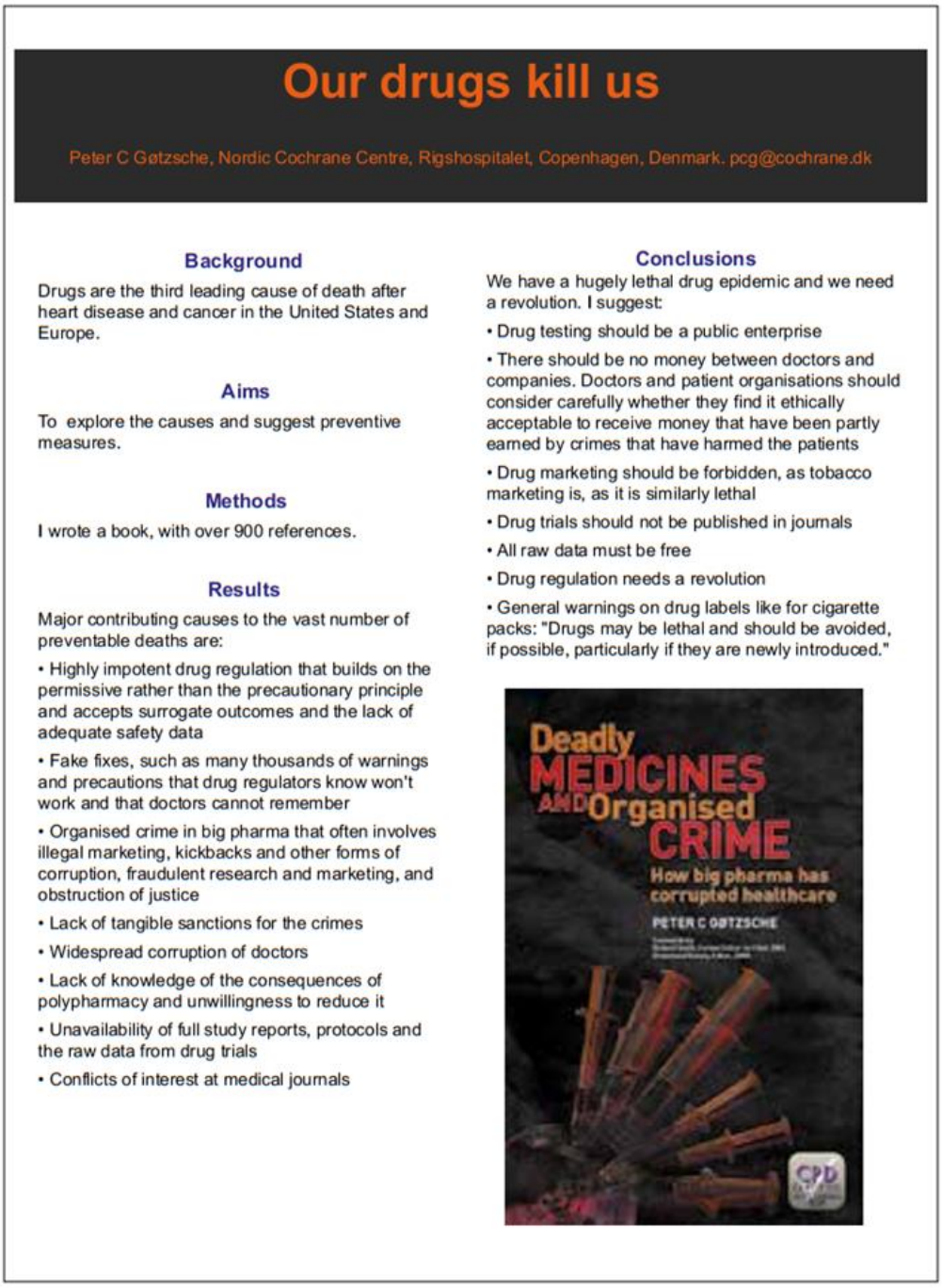
General practitioner Des Spence wrote in the *BMJ* that I am "a tough guy, happy to push over the apple cart of perceived wisdom right in front of the vendors, wearing an expression that seems to cry out, 'Come and get me if you think you're hard enough.'"[245]

It was very liberating for me to get this support from respected colleagues and to get the book out. The editor didn't change anything, in contrast to my Odyssey where I ran into requests of writing something else all the time.

Steen Græsted Larsen, the importer of generic drugs (see page 38), convinced me that I should translate the book into Danish. I submitted it in the mid-afternoon on 20 June to People's Press, and at 9 o'clock the next morning I got an email from director Jan Degner: "The editors and I have been reading last night and we are very excited. It is an excellent and very sensational book." It came out simultaneously with the English original on 1 September 2013. Ten days later, I presented a poster at the Preventing Overdiagnosis conference in Dartmouth, New Hampshire, in which I joked. The Methods section was likely the shortest ever published: "I wrote a book, with over 900 references" (see next page).

The book was very well received and created enormous interest.[246] I was interviewed by three Danish TV channels[247] and was contacted by 34 TV crews from seven countries. Most

of them wanted to make documentaries, and two fiction writers developed plots based on the book. Years later, Hanne-Vibeke Holst[248] and Sissel-Jo Gazan[249] asked for my help with their crime novels.



# Our drugs kill us

Peter C Gøtzsche, Nordic Cochrane Centre, Rigshospitalet, Copenhagen, Denmark. pcg@cochrane.dk

## Background

Drugs are the third leading cause of death after heart disease and cancer in the United States and Europe.

## Aims

To explore the causes and suggest preventive measures.

## Methods

I wrote a book, with over 900 references.

## Results

Major contributing causes to the vast number of preventable deaths are:

- Highly impotent drug regulation that builds on the permissive rather than the precautionary principle and accepts surrogate outcomes and the lack of adequate safety data
- Fake fixes, such as many thousands of warnings and precautions that drug regulators know won't work and that doctors cannot remember
- Organised crime in big pharma that often involves illegal marketing, kickbacks and other forms of corruption, fraudulent research and marketing, and obstruction of justice
- Lack of tangible sanctions for the crimes
- Widespread corruption of doctors
- Lack of knowledge of the consequences of polypharmacy and unwillingness to reduce it
- Unavailability of full study reports, protocols and the raw data from drug trials
- Conflicts of interest at medical journals

## Conclusions

We have a hugely lethal drug epidemic and we need a revolution. I suggest:

- Drug testing should be a public enterprise
- There should be no money between doctors and companies. Doctors and patient organisations should consider carefully whether they find it ethically acceptable to receive money that have been partly earned by crimes that have harmed the patients
- Drug marketing should be forbidden, as tobacco marketing is, as it is similarly lethal
- Drug trials should not be published in journals
- All raw data must be free
- Drug regulation needs a revolution
- General warnings on drug labels like for cigarette packs: "Drugs may be lethal and should be avoided, if possible, particularly if they are newly introduced."




The Danish version was on the bestseller list for many weeks and it was the second most wanted non-fiction book at libraries half a year later.[250] A year later, I was the 7th most cited researcher in the media from the University of Copenhagen, with 636 citations.[251]

The book provided, and still does, the most extensive documentation ever gathered in one place of how and to what extent the pharmaceutical industry has corrupted healthcare. The Auckland Women's Health Council wrote that, "If you only read one book over the next

six months, then for the sake of your health and your sanity this is the book you must read. It is immensely readable, terrifyingly funny in parts and just plain terrifying in others."[252]

Henry Bauer wrote in *Journal of scientific exploration*[253] that my book "is a formidably important work … Read it very slowly … the subject matter is far too depressing and sickening to be taken in all at once ... Almost every page has something worth quoting … I think Gøtzsche remained able to write it in part because he retains sanity by means of ironic gallows humor and turns of phrase that can also help the reader keep reading, as with the chapter heading, *Merck, where the patients die first* in response to Merck's incessant advertising slogan, *Merck, where patients come first*."

The book won the British Medical Association's Annual Book Award in the category Basis of Medicine in 2014. It was highly commended as compulsory reading for medical students and junior doctors and was praised for its clear language - fraud, corruption, and criminality.

The book came out in 18 languages. It still sells well and is still being translated; a version in Hungarian is on its way.

I have estimated that our prescription drugs are the leading cause of death and that psychiatric drugs are the third leading cause of death, after heart disease and cancer.[254] On the first page in my book, I say that, "If drug deaths had been an infectious disease, or a heart disease or a cancer caused by environmental pollution, there would have been countless patient advocacy groups raising money to combat it and far-ranging political initiatives. I have difficulty understanding that - since it is drugs, people do nothing."

Most of the many millions of patients that have been killed by drugs didn't even need the drugs that killed them. This makes the drug industry far worse than the mob, and my book ends with a joke that I asked Franz Füchsel, one of the Muhammad cartoonists, to draw for me:


A few months before the book came out, I noted in an interview that, as there are too few who are ill, the biggest source of income for the drug industry is healthy people.[255] Why

don't our authorities do something? The whole world panicked over the COVID-19 pandemic, but the virus made in China[256] killed far fewer people than those we kill with our drugs.

On page two in the book, I say that "The main reason we take so many drugs is that drug companies don't sell drugs, they sell lies about drugs ... If we wish to buy a car or a house, we may judge for ourselves whether it's a good or a bad buy, but if we are offered a drug, we have no such possibility ... The reason patients trust their medicine is that they extrapolate the trust they have in their doctors into the medicines they prescribe. The patients don't realise that, although their doctors may know a lot about diseases and human physiology and psychology, they know very, very little about drugs that hasn't been carefully concocted and dressed up by the drug industry."

Two days after my book came out, Peter Schwarz, chairman of the Danish Medical Societies, attacked it violently in a newspaper with the title, *Peter Gøtzsche is totally off limits*,[257] which I responded to.[258] He tried to defend a system that is impossible to defend by resorting to lies and personal attacks.

Schwarz said that I had made "such outrageous claims about the medical profession as habitual criminals and the industry as a mafia that it borders on dishonesty." The Inuits say that if you swing a whip over a pack of sleigh dogs, the one that feels hurt will howl.

He claimed my documentation was outdated: "It is very strange that a person who calls himself an expert in the field has apparently not followed what has happened in the past 10-20 years, where fundamental changes have taken place regarding the openness and collaborative relationship between medical researchers and the pharmaceutical industry."

This is what the CEO of Pfizer could have said. Even though the crimes have worsened, the industry says the opposite. The ten cases I described were recent, from 2007 to 2012. My documentation of all this, over 310 pages with 1122 references, Schwarz called an undocumented suspicion of dishonesty!

The widespread collaboration between doctors and industry is honourable, fruitful and necessary, Schwarz said while collaborating with Eli Lilly and Merck whose fraud and crimes have cost the lives of hundreds of thousands of patients.

Two years earlier, when I noted that the proposed revision of the law about clinical trials ignored the biggest problems, one of which was that cheating with the research is common, which I documented,[259] Schwarz replied that Danish researchers are not a bunch of habitual criminals.[260]

I don't think Schwarz had read my book. Another man of the system - even more than Schwarz - Jens Kristian Gøtrik, praised it and noted that the medical profession contributed to the misdeeds.[261] He has chaired the Danish Medical Association, the Cancer Society, the Danish Board of Health and the Medical Devices Industry.

Former Editors-in-Chief of some of our most prestigious journals do not share Schwarz's views either. Marcia Angell, from the *New England Journal of Medicine*, stated: "I find it hard to imagine that a system this corrupt can be a good thing, or that it is worth the vast amounts of money spent on it."[262]

Like Schwarz, the drug industry lied about the facts. Pfizer, one of the world's most criminal companies, which has been convicted of organised crime, claimed that what I and many others, including judges and juries in court trials, had documented, wasn't true.[263] They said my book was a mixture of claims, attitudes, and interpretations, they couldn't recognise. Well, it documents that Pfizer are habitual criminals. Such people always say they are innocent.

The associations of the Swiss pharmaceutical companies declared that, “This unqualified, polemical all-round attack does not at all reflect reality. To accuse an industry, which is extensively inspected and controlled by highly qualified institutes, of organised crime is absurd and disrespectful.”[264]

CEO Tim James from Medicines Australia, an association of drug companies, wrote in the *Sydney Morning Herald* that I am “a well-known anti-industry agitator whose statements that the industry is engaged in organised crime and mass murder are highly political and fanciful, and are obviously designed to peddle his book.”[265]

The Danish Association of the Pharmaceutical Industry was encouraged several times to debate with me on TV,[266] but they declined, uttering that I had embarrassed myself, talked about conspiracy theories, and claimed that they could not recognise at all what I had documented in my book, which they called accusations even though they are facts.[267] They claimed that there are no examples in my book that the Danish market is affected by the illegal methods.[268] There are many examples, e.g. the European Commission fined Lundbeck in 2013 for €94 million for violating antitrust laws by paying other firms to delay marketing of their copies of citalopram. Danes also suffer from crimes committed by foreign companies, e.g. when they hide lethal harms of their drugs.

Deputy director of the Association, Henrik Vestergaard, also lied. He said that "when you collect cases from the last 90 years from all the countries in the world ... and then conclude that the entire system is corrupt, this is simply wrong."

Lundbeck's research director, Anders Gersel Pedersen, called my book muddle-headed nonsense and believed it showed I had a "total lack of self-criticism" in my judgments. I noted that, according to Lundbeck's own judgment, antidepressants reduce suicides in children and young people whereas the Board of Health advises against using these drugs because they increase the risk of suicide attempts. Pedersen called it a "foolish discussion," if 455,000 Danes who got a prescription for a depression drug were too many.

Psychiatrist Henrik Day Poulsen repeated the industry’s lies in a newspaper claiming there had been very few examples of cheating. He stated that I "know practically nothing about psychiatric diseases," which was untrue, as I had researched psychiatric drugs for six years, whereas he considered himself entitled to say it is okay that over 700,000 patients each year receive a prescription for an NSAID although this is terribly wrong and outside his area of expertise.

Four months after my book came out, Schwarz and Leif Vestergaard Pedersen, director of the Cancer Society, doubted my professionalism. I replied with the title, *When the truth is unwelcome, the messenger is shot*.[269] When I point out that an intervention is harmful, the standard argument, which Pedersen also used, is that I am scaring the patients. This is a horrible argument. If we are not allowed to document when our interventions are harmful, it will be difficult to ever get rid of them. And it is more important to avoid harming the patients than to avoid scaring them. Furthermore, Pedersen’s unsolicited paternalism is misguided. The public has a right to know the facts.

Unfortunately, many people in leading positions are like Pedersen. Mads Koch Hansen, the chair of the Danish Medical Association, believed it was "a poor and very detached goal" when both I and an editorial in a leading newspaper called for a plan from the Minister of Health to reduce the consumption of psychiatric drugs, even though the psychiatrists had themselves admitted that overtreatment is a much bigger problem than undertreatment.[270] Hansen feared that my article would cause seriously ill people to stop taking their drug. With this attitude, we will continue harming people with psychiatric drugs.

In Norway, my book was violently attacked by Steinar Madsen, director of the Norwegian Drug Agency, in the medical journal.[271] He called it a crusade against the drug industry and that using the words corruption and fraud were exaggerations. His book review was full of hints that it wasn't correct what I had written, but he gave himself a free ride, as he didn't offer a single example. A researcher noted that it was obvious that Madsen had felt hurt by my criticism and that, based on the extensive documentation I had provided, it was beyond doubt that the industry engages in corruption and fraud, e.g. it would not have been fined for over 10 billion dollars for no reason.[272]

The way the Cochrane leadership reacted was also deplorable. Cochrane's CEO Mark Wilson denounced my book (see page 314).

I love satire, and because of the book's success, I contacted *The Daily Show* in New York and asked if they were interested in presenting it. They didn't reply, but a year later, they found my book themselves. Nate Witmer, the producer on *The Daily Show* with Jon Stewart, wrote that he would love to ask me a few questions and that they might want to interview me for the show.

They were highly effective. We had a phone call where they asked if I was "free to travel for a shoot in New York city early next week?"

I looked forward to sitting with Jon Stewart while he presented by book. But that was not the idea. I was going to play the role of *Deep Throat*, revealing the dirty secrets of the drug industry in a garage in New York.

It was very funny and informative.[273] The real *Deep Throat* was FBI's Associate Director Mark Felt who provided key details about the Watergate scandal.

Peter and comedian Michael Che


Pills as food

## Why some of us consider medical journals dead

When I compare the praises of my book about organised crime in the drug industry with the journal editors' robotic excuses for rejecting my paper about it (see previous chapter), and when I think of all the other numerous cases of censorship I have been exposed to, I conclude that medical journals are more and less dead. Richard Smith, previous editor of the *BMJ*, agrees: "It's interesting to me in a way that journals are still alive, because I think there are a lot of reasons why they should be dead."[274]

Richard is one of the very few people I have met who is similarly outspoken as I am. In the book's foreword,[275] he wrote about me: "He is not a compromiser or a dissembler, and

he has a taste for strong, blunt language and colourful metaphors. Some, perhaps many, people might be put off reading this book by Peter's insistence on comparing the pharmaceutical industry to the mob, but those who turn away from the book will miss an important opportunity to understand something important about the world - and to be shocked."

The public appreciates this type of information whereas journal editors fear losing advertising income or income from selling reprints of industry supported trials.[276] In an interview with *Science Magazine*, I said that when we studied if journals with many drug ads were more likely to put a positive spin on the results in the abstracts, several journals declined to cooperate.[277] There was "a level of secrecy that stinks."

The incentive for corrupting medical journals is huge. A drug industry insider told *BMJ* in 2005 that if a "favourable" research paper was published in a prestigious medical journal, the paper might be worth £200 million to the company.[278] By buying doctors and editors, the industry has transformed medical science from a public good whose purpose is to improve health into a commodity whose primary function is to maximise financial returns.

The drug industry's preferred journal is the *New England Journal of Medicine*. I give many examples in my book crime and elsewhere of fraudulent trials that ended up there and of abstracts of trials that are highly misleading but very useful to sell useless and dangerous drugs. The journal is colloquially known under this name:

The NEW ENGLAND
JOURNAL of MEDICALISATION

Many of us – highly esteemed researchers that have published numerous papers in prestigious journals like the *NEJM* - find that the traditional publishing model is broken. Research published in medical journals is often unreliable; research that threatens economic, guild or political interests is difficult to publish; it can take years before articles appear in print if ever; and publishers are highly exploitative. Authors pay large publication fees for open access; they work for free as peer reviewers; libraries cannot afford the subscription fees; and the profits of big publishers are now even bigger than those of the drug industry.

My most important papers were impossible to publish in specialty journals because they threatened the *status quo*. I often felt I had been the victim of anonymous hangmen who did the dirty job for the editors by inventing unwarranted criticism of my research in their peer review reports that allowed the editors to summarily reject my papers.[279] Peer reviewers are often corrupt. Over half of the US peer reviewers for the *BMJ*, *JAMA*, *The Lancet*, and *New England Journal of Medicine* get money from the drug industry.[280]

The postulated reasons for rejection are rarely the real reasons and they can be quite amusing. Robert Whitaker and I were told that, "We only accept articles of the highest quality and novelty" when the editor rejected our paper, *The pervasive financial and scientific corruption of psychiatric drug trials.* I was surprised by this rejection because it came from Ivor Ralph Edwards, who had otherwise been very helpful and had accepted many of my papers that demonstrated how harmful psychiatry is in his journal, *The International Journal of Risk & Safety in Medicine*. Three of the peer reviewers were positive; the fourth found our paper overly aggressive and polemic, which was not at all the case. We just described the plain facts. You can judge for yourself if you read our paper, which we published on my website.[281]

The ubiquitous corruption of medical journals is a formidable barrier for saying what you want to say. In 2005, I published an article in *NEJM* together with the editors of the Norwe-

gian and Danish medical journals where we called for registration of all clinical trials in a register, demanding the addition of all results after the researchers had published their trial.[282]

Letters came in and we responded to them. We thought. We wrote that sanctions against researchers or companies that failed to report their data should be introduced, but Jeffrey M Drazen, the editor, deleted "companies" from our manuscript and changed our call for all data to be reported, which became "an agreed-on synopsis of the data."

I had never experienced anything like this before, where an editor interfered to this extent with what the authors believed and wished to say in reply to reader comments. Drazen gave the drug industry a helping hand. A synopsis of the data would allow the companies to do business as usual: To present manipulated analyses and hiding drug harms, increasing the number of patients killed by drugs. We were exposed to this just after the Vioxx scandal where *NEJM* also preferred to let the patients die while they and Merck cashed the money (see page 265). These editors are ruthless. It is all about money.

We protested but Drazen did not accept to remove the bit about only demanding a synopsis.[283] His journal is very beholden to drug companies, which gives its owners a gigantic income. When we tried to find out how much the big journals own on selling reprints and advertising space to drug companies, *NEJM* refused to give us the data, even when we only asked for a percentage of the total income.[284] But the journal's owner, Massachusetts Medical Society, listed $88 million in total publishing revenue for the year ending 31 May 2005. For a European, this is not only an astronomical sum. It is beyond our wildest imaginations.

In the late 1990's, a colleague of mine was commissioned to write five articles for a pharmacy journal. In his second article, he addressed control of cholesterol and described the biochemistry, diets, and drugs, which he didn't "entirely glamourise." The feedback was very positive. But already the next day, the editor called my colleague. She was very apologetic and explained that she needed to cancel the rest of the series. She had convinced Parke Davis to pay for an expensive colour advert for its recently launched cholesterol-lowering drug, Lipitor, which was inserted on the page opposite the first page of the article. Parke Davis had phoned her and said that if she ever published another article by my colleague, they would cease advertising.

I have argued that we should allow anonymous authorship in some situations.[285] Journalists use anonymous sources when it is important to protect whistleblowers from repercussions. Without anonymity, many potential whistleblowers would prefer to keep quiet, even though they might save many lives by speaking out.

The FDA is a good example that we sometimes need anonymous authorship. The FDA has suppressed information about drug deaths on many occasions and has attacked whistleblowers within the agency. When David Graham, associate director in the FDA's Office of Drug Safety, showed in 2004 that Vioxx increases coronary heart disease, he was accused of scientific misconduct and of being a liar and needed congressional protection to keep his job.[286]

When it became known that AstraZeneca's COVID-19 vaccine can cause a fatal autoimmune coagulation disorder involving the thrombocytes, a researcher told me that another vaccine produced the same autoantibodies. However, she did not dare publish her data: "Because of the climate at my workplace, I would have to do it anonymously." I suggested we published together, with her being anonymous, but she did not take the offer.

As there are examples where corrupt editors have leaked confidential information to the company, it should be possible to even submit a manuscript anonymously via some intermediary.

I also argued that the current system, where the author is known for the peer reviewers who are anonymous, must be changed into one of total openness – which is the best procedure - or total anonymity, as the system is widely abused to censor unwelcome research.

Science needs to be debated and criticised, e.g. in letters to the editor, but this is also an area filled with frustrations. In the *New England Journal of Medicine* and *The Lancet*, letters must not be longer than 175 and 250 words, respectively, and must be submitted within tree and two weeks, respectively, after publication of the original article, and only five references are allowed.

This sends a clear signal: We are hostile to criticism and scientific debate. If there are several flaws in an article, it can be impossible to discuss them within these constraints, and it is difficult to see any good rationale for them because journals are published electronically. Moreover, the time limit is discriminatory. In poor countries, it could take longer than a couple of weeks before the researchers see the newest issue of a journal.

Imagine if evidence for a court case about a crime was only allowed if it was collected within the first 2-3 weeks after the crime was committed. It makes no sense. Fraud in medical research is prevalent and its detection should have no closure date.[287] It might even only be detectable when the researchers have published additional papers based on the same data.

It is a serious obstacle to scientific progress that it is often impossible to get a letter to the editor accepted describing serious errors in a published article. Editors of prestigious journals do not like losing face, so they often reject letters that document flaws that make an article totally invalid. I have experienced this from *NEJM* and *Lancet*, as have many other researchers I have collaborated with. *Lancet* even refused to publish a letter where I proved that the authors had lied about their research to circumvent a criticism I had published, also in *Lancet*![288]

In 2008, Richard Smith wrote that, “In what has been called the age of accountability, editors have continued to be as unaccountable as kings. But stories of editorial misconduct are growing,” which he illustrated with an egregious case where the editors violated almost every ethical standard established for editors.[289]

Epidemiologist Jan Vandenbroucke, with whom I worked to produce guidelines for good reporting of observational studies (STROBE), has noted that “Without the possibility of open debate, science simply ceases to exist.”[290]

After a long career in science, I no longer find it attractive to publish in medical journals.[291] It is more satisfying to publish on a website or write books where I can say what I want instead of enduring years of hostile peer reviews, rewritings, resubmissions, new peer reviews, and ultimately often facing rejection anyway.

I am not alone. The crisis in scientific publishing is so pronounced that more and more researchers - including some of the very best - now prefer to publish on websites for free, reaching far more people than journal articles do.[292]

I have described that when editors try to defend freedom of speech or a journal’s high standards, it can cost them their job.[293] In 1999, editor Jerome Kassirer at *NEJM* was

dismissed. He opposed that the journal's good name should be used for a number of secondary products, over which the editors would have no quality control.

I met with Kassirer twice, the first time in Warszawa in 2010. We had been invited to lecture at a meeting arranged by the Polish Academy of Sciences about ghostwriting, which means that the author does not appear anywhere in the paper. I explained why it is scientific misconduct, and Kassirer handed me a note when I sat down next to him: "Great talk."

*JAMA* and *Lancet* went ahead and polluted the publishing atmosphere with an avalanche of secondary journals. I wrote about this in 2025:[294]

"I became so irritated about reading a lousy paper in *Lancet Digital Health* that I wrote to some colleagues that all these secondary journals pride themselves with borrowed feathers from the original journal, *The Lancet*: 'When will we see *Lancet Gobbledygook*, *Lancet Yesterday's Findings*, *Lancet Future Findings*, *Lancet Wishful Thinking*, *Lancet Bullshit*, *Lancet Unproven Hypotheses*, *Lancet Uninterpretable Research*, *Lancet Non-reproducible Research*, *Lancet Superfluous*, *Lancet Moneymaking*? (Oh, sorry, we already have that: The all-too industry-friendly *The Lancet*)."

In 1999, *JAMA* published an article showing that university students did not think oral sex was sex. The article was relevant for the ongoing impeachment case against President Bill Clinton, but the editor, George Lundberg, was fired without due process.

Canadians can also have a strained relationship with sex. The editor of the *Canadian Medical Association Journal*, John Hoey, and his deputy, Anne Marie Todkill, were fired in 2006 for having published an article showing that pharmacists interfered inappropriately by asking personal questions when women turned up at a pharmacy to be dispensed postcoital pregnancy prevention (Plan B). In the USA, the Bush administration, without any professional justification, had delayed the approval of Plan B.

In 2007, the editors of *Croatian Medical Journal*, Matko Marušić and Ana Marušić, came in deep trouble even though they had nothing to do with the case. Iain Chalmers detected that Professor Asim Kurjak had repeatedly plagiarised the work of other researchers and he asked the University of Zagreb repeatedly to deal with the fraud. When nothing happened, and Kurjak continued plagiarising, Iain published his observations in the *BMJ.*

The whole academic environment in Zagreb was deeply corrupt.[295] False rumours were circulated, e.g. that the Marušićs had written Iain's article; the Dean of Zagreb's medical school, Nada Cikes, lied; a report documenting the fraud went missing; the Rector of the University, Professor Aleksa Bjelis, said plagiarism was a benign problem; demands were raised that Matko Marušić be assessed psychiatrically because he had drawn public attention to the corruption at the University of Zagreb; Natasa Skaricic, a journalist from the university who covered the scandal, was sacked; and Mirjana Juricic, a judge who ruled that the demand that Marušić be examined psychiatrically was an illegal attack on his human rights, faced disciplinary action. The Balkans is a violent place, it seems.

Freedom of speech and editorial independence from special interests are some of the most important principles we have. They form the foundation of Western civilisation, and we cannot abstain from it to accommodate the wishes of people with their own agendas, conflicts of interest, or prejudices.

It is quite risk-free to spread lies but censorship is not the solution. I have suggested that stricter measures be taken in criminal law against those who lie.[296]

# 8 Opening up EMA's archives and lobbying the European Parliament

In 2007, my PhD student Anders Jørgensen and I decided to challenge the secrecy at drug agencies.[297] We chose slimming pills as our test case because they were all dangerous.

We asked the Danish Drug Agency for the clinical study reports and corresponding trial protocols for sibutramine, with the catchy name Reductil. Abbott, the manufacturer, had only published half of their studies and there were concerns about an increased risk of heart attacks.[298] The Agency contacted Abbott, which refused to grant us access. After a year of negotiations, when the Agency had overruled Abbott, Abbott's lawyer sent a complaint to the Ministry of Health.

I had good relations with the chairman for the Committee on Health in Parliament, Preben Rudiengaard, who ensured I got a meeting with the Minister, Jakob Axel Nielsen. He was so interested in what I told him that the scheduled half an hour became a full hour even though the civil servant said several times that he would be late for his next meeting. I convinced him that we should not support a system where only the positive research results are published while the negative ones are inaccessible.

Nielsen dismissed Abbott's complaint and we got access to 14,309 pages of documents. They were not of much use, however, because the Drug Agency had redacted all the detailed descriptions of adverse effects in the individual patients - even though we could not identify who the patients were, as there were no names - which made it impossible for us to study the harms more closely.

But Abott's letters to the agency were included, and they were revealing. There was a statement from cardiology professor Christian Torp-Pedersen that it could harm the company's commercial interests if we got access. This was shocking.

As the drug was suspected of causing heart attacks, Torp-Pedersen should have protected his patients rather than the company, but he had financial conflicts of interest.[299] Before we got access to the documents, Abbott and Torp-Pedersen had finished a huge study, which showed that Reductil increased the risk of heart attacks and stroke![300] The Drug Agency therefore withdrew the drug from the market, and we abandoned our project.

In 2007, we also contacted the European Medicines Agency (EMA) to get access to data on two other slimming pills, orlistat and rimonabant. We argued that secrecy is not in the patients' interest and noted that we hadn't found any information that could compromise commercial interests in 44 trial protocols of industry-initiated trials we had obtained from a research ethics committee.[301]

In the middle of the process, rimonabant was withdrawn from the European market after studies done by independent researchers had found that the drugs' harms, which included severe depression and increased risk of suicide, were more serious and common than the manufacturer, Sanofi-Aventis, had shown in their trials.

Although EMA's aim is to protect the public, EMA didn't address our arguments but replied that the documents could not be released, as it would undermine commercial interests. We appealed to EMA's executive director, Thomas Lönngren, and asked him why the agency considered that the commercial interests of the drug industry should override those of the patients. We argued - with convincing examples - that a likely consequence was that patients would die unnecessarily and would be treated with inferior and harmful drugs because their doctors didn't know what their true benefits and harms were.

Lönngren sent us a cut-and-paste type of letter, similar to the first one, ignoring our request for clarification, and told us we could lodge a complaint with the European Ombudsman, P Nikiforos Diamandouros, which we did. I have uploaded the various documents in the case on my website.[302]

EMA had four main arguments against disclosure: protection of commercial interests; no overriding public interest; the administrative burden involved; and the worthlessness of the data to us after EMA had redacted them.

I'm sure Lönngren felt his armour was impenetrable, but he had underestimated the Ombudsman who was a most impressive person. He noted that the risk of a commercial interest being undermined must be reasonably foreseeable and not just hypothetical. Furthermore, his staff inspected the relevant reports and protocols at EMA in London and concluded they didn't contain confidential information.

The Ombudsman also noted that we had established an overriding public interest. He asked EMA to justify its position, which Lönngren arrogantly ignored; instead, he claimed we had not given evidence of the existence of a public interest. This was false. Moreover, a suspect asked for his alibi on the day of the crime doesn't get off the hook by asking for someone else's alibi.

The Ombudsman also rejected Lönngren's claims about the administrative burden and the uselessness of the documents after EMA had redacted them. In fact, when we received the documents, nothing was redacted!

Since EMA continued to ignore the Ombudsman, he played his final card, three years after our request: He accused EMA of maladministration in a press release.

EMA had no choice other than to reverse their stance; otherwise, they would get the whole European Parliament on their neck, and there would be a huge scandal.

EMA was ruthless in their dishonesty. They now gave the impression that they had favoured openness all the time and had agreed with the Ombudsman. This is how drug companies operate. They fight forcefully against openness, but when there is no escape, they pretend they have been in favour of it all the time. They even give the impression that it was their own idea, which EMA also did.

It was a major breakthrough for public health and the biggest achievement in my career, but EMA took the credit. It was quickly forgotten that I was the one who had accomplished it, working closely with the Ombudsman, even though we wrote about it in the *BMJ*.[303]

I participated in meetings in the European Parliament when a journalist phoned me to get an interview. I was a bit annoyed. Why should I talk to *Financial Times*? I have no interest in business matters. But the article was excellent and the journalist noted that the new openness could revolutionise the drug industry.[304] Amusingly, the article said that a concern raised was the danger of misuse and misinterpretation of patient data, without the safety valve of a regulator. Elmar Schnee, chief executive of Cardiorentis, a biotech company, said that "Patients could get very confused with the information coming out. I hope this transparency gets stopped. People could do a lot of stupid things with it."

Nothing can be more stupid than letting the drug industry control access to the data and believing that drug regulators protect us from harmful drugs. The Ombudsman also felt it was a very important case and invited me to attend the annual meeting where he informed the European Parliament about last year's accomplishments.

The good news travelled around the world and was mentioned in *Science*,[305] and three months later, EMA declared it would widen public access to documents, including trial reports and protocols.

Our case illustrated beyond any doubt that drug agencies side with the drug industry and puts their profits over patients. It was an aggravating fact, which we noted in our complaint, that EMA helped the drug industry with violating the Declaration of Helsinki, which states that researchers have a duty to make the results of their research on humans publicly available. By violating human rights, EMA was complicit in the exploitation of patients for commercial gains and for their suboptimal treatment. Moreover, the Declaration says that medical research must be based on a thorough knowledge of the scientific literature and that if the knowledge base is incomplete, patients may suffer and cannot give fully informed consent. Thus, by being secretive, EMA acquiesced to unethical research in future.

Our crushing arguments, including that thousands of unnecessary deaths could be avoided every year, if the public had access to the unpublished information, didn't bother EMA the least, and Lönngren ensured that my PhD student was unable to do the work we had planned. After his efforts at protecting the industry, he quit EMA in a shameless fashion. Although he knew he was forbidden to provide product-related advice to drug companies or take managerial, executive or consultative positions in the drug industry for a period of two years, he became director of a new company, Pharma Executive Consulting Ltd, in November 2010 that did exactly this while still being employed by EMA.

On 22 November 2012, EMA held a workshop on clinical trial data and transparency at its headquarters in London that made history. Its new head, Guido Rasi, announced that "We are not here to decide if we will publish clinical trial data, only how." I looked for a seat in the room, but Rasi came down and told me I should join the panel at the podium.

The industry representatives were stunned. Their usual arguments for secrecy were torn into pieces during the discussions, and Kent Woods, the head of the UK drug regulator, looked like a spill over from the past when he argued that EMA's new openness and transparency wasn't needed. I had never seen the almighty drug industry lose a public battle so totally as during this afternoon. They made complete fools of themselves, some of which can be seen in a video made available after the meeting.[306]

In my allotted five minutes, I pointed out that I found the argument that making the data available will result in bad analyses, amusing because the situation could not be worse than when the only people who see all the data for a new drug are those inside the company that stands to earn a lot of money from the product[307] (by torturing the data).

There had been an earlier case.[308] Liam Grant, whose son committed suicide while on the acne drug isotretinoin (Roaccutane from Roche), had tried to find out which harms the company had informed the authorities about before marketing approval. EMA granted him access to the reported harms in 2010. In 2002, Danish journalists had also tried to get access to the harms, as described in the Periodic Safety Update Reports (PSUR), from the Danish Drug Agency. The agency was willing to provide access, but Roche blocked it by arguing it would create a substantial risk for considerable losses and even threatened to sue the Danish state if this happened. Sue a state because fewer patients will take a drug after they found out it might kill them? Roche behaved as gangsters and also pushed heroin (see page 257).

To regard harms reported by patients or their relatives as the company's private property demonstrates an outrageous disrespect for patients and human lives.

I 2010, I started to collaborate with a Danish Member of the European Parliament, Margrete Auken, from the European Green Party. She called me one day and asked if I would give a talk about genetic screening in Strasbourg. I declined, as I had never worked with this, but said I could lecture about screening for cancer and general health checks. By the end of my talk, I mentioned briefly my breakthrough with EMA. I met with the Ombudsman and a German politician, Peter Liese, from the Christian Democratic Union (CDU), part of the European People's Party, a doctor who was very interested in these issues. I wrote a report for him about access to data, which I published.[309]

This marked the start of my career as a scientific lobbyist in the European Parliament. I went to many meetings in Bruxelles the next three years and gave talks for parliamentarians and the European Commission. I collaborated closely with Margrete and her network that included David Hammerstein, a Californian who went to Spain when he was young, stayed there, and got elected to the European Parliament for Spain before he became a lobbyist for big consumer organisations, at the time the Trans Atlantic Consumer Dialogue. Margrete and David became close friends.


Margrete Auken


Peter Liese


David Hammerstein

A year later, David invited me to give a talk at a conference in Parliament about treating knowledge as a public good, which I published.[310] The respect for trial participants who often run a personal and unknown risk by participating in trials requires that they - and, therefore, also society - be seen as the ultimate owners of trial data. Research can only be a public good, if we can see the data.

Data sharing would lead to tremendous benefits. Much research can be performed at almost no cost on existing data. Furthermore, the incentive for bias and fraud will be reduced when other researchers can check the data.

My article ended this way: “If commercial or academic success depends on withholding data that are important for rational decision making by physicians, patients, and governments, then there is something fundamentally wrong with our priorities in health care.”

Margrete, David and I worked on introducing new laws about access to clinical study reports, and Glenis Willmott, a UK Labour member, was a good ally. When the *BMJ* in 2015 published the article, *The pioneers of transparency*, they noted that I “had been working tirelessly for years to get the European Medicines Agency to release more data.”[311] They also mentioned Iain Chalmers, Tom Jefferson, and Doug Altman, and, among those who listened, Glenis Willmott, rapporteur for the EU Clinical Trials Regulation. She said that “her fellow MEPs did understand the issues but that their positions started at complete opposite ends of

the spectrum, some wanting every single piece of raw data published, while others wanted even less transparency than the European Commission had proposed."

One of those against transparency was a French politician, Philippe Juvin. As he was a doctor, his views on public health issues were widely respected, so we needed to change his views. One day, when I was in Parliament with Margrete, he walked up to Willmott after the meeting. I grabbed the opportunity, went down to them and said, "Hi Glenis," to signal that I was acquainted with influential people, and asked if I could have a brief word with him.

When he heard I was from Cochrane, he reacted negatively, but I succeeded in five minutes to convince him that we needed to get access to the data.

In 2012, I published extensive comments on the deficiencies in a proposed new EU regulation of clinical trials.[312] In the end, we succeeded changing a political majority for continued secrecy into a crushing victory for openness: On 2 April 2014, the EU Parliament agreed to the new Trials Directive with 594 votes for, 17 against, and 13 abstentions.

It was very exciting to be part of this, and I asked my friends in the Trans Atlantic Consumer Dialogue and Health Action International if I should try to become elected to the Parliament. They said I would be of much greater use if I continued being a scientist.

In 2016, some MEPs wanted me to become a member of EMA's Management Board, but unfortunately, a majority preferred an MEP instead. It would have been great fun to sit there. But not for EMA.

During my career, I have taken on the role as a scientific lobbyist on many occasions. I have met with 8 Ministers of Health in Denmark, which led to important policy changes in three cases: Introduction of health technology assessment in Denmark, getting access to clinical trial data in the Danish Drug Agency, and dropping the government's plans on introducing regular health checks because we had shown in our review of the randomised trials that they don't work and are likely harmful.

In 2012, Sidney Wolfe from Public Citizen in Washington DC wrote to me that he admired my persistent and successful efforts to push the EMA to do what they should have done long ago, and he wanted to know if anyone was trying to obtain the same with the FDA.

We met a year later at the Selling Sickness conference in Washington. He invited me to see his offices and we had dinner in his home. I really appreciated to get to know such a giant as Sidney and his wife, Suzanne Goldberg, and I met him again at a Prescrire meeting in Paris.

Sidney died in 2024, aged 86. *New York Times* mentioned that he managed to get more than a dozen drugs removed from the market, and warning labels affixed to dozens of others.[313] He took on more than just drugs and had a sign that said, "The people have been screwed long enough." He noted that, "Somebody has to look out for people who are being manipulated by the hospitals, doctors, insurance and drug companies."

In 1980, he self-published the book, *Worst pills, best pills: a consumer's guide to avoiding drug-induced death or illness*, which sold more than 2.2 million copies. He was a genius.

In 2013, two US drug companies, AbbVie and InterMune, challenged EMA's new openness policy at the European court. In an interim ruling, the court suspended EMA from granting a third-party access to documents on Humira (adalimumab) for Crohn's disease and on Esbriet (pirfenidone) for idiopathic pulmonary fibrosis.

EMA challenged the interim suspension, and the European Court of Justice annulled the orders and referred the matter back to the EU's general court.

Humira from AbbVie (earlier Abbott), a monoclonal antibody, was the world's top selling drug, but it can cause life threatening harms. At a meeting in Bruxelles, AbbVie made it clear that it nonetheless regarded clinical trial data on adverse events as confidential information that it was entitled to keep to itself.

This elicited strong reactions from European drug regulators.[314] Aginus Kalis, head of the Dutch Medicines Evaluation Board, asked Neal Parker from AbbVie: "You are aware that you are working in the healthcare industry ... with patients and human beings?" Hans Georg Eichler, EMA's senior medical officer, said: "I have been a regulator for many years, and I am totally flabbergasted."

It was now a fight for good versus evil. I noted in the *BMJ* that non-disclosure of trial data kills people in huge numbers.[315] Disgracefully, the major drug industry associations in Europe and the USA supported the two court cases thereby showing their true faces when they claim they work for the patients. I urged people to sign a petition calling on AbbVie and InterMune to drop their legal actions against EMA and I encouraged doctors to boycott products from Abbott, AbbVie, and InterMune.

The gangsters who had tried to hide the corpses from public review did not prevail. But Merck and PTC Therapeutics, two other US companies, appealed an initial ruling in February 2018 that had supported EMA's position that clinical study reports should not be considered confidential.[316] Most stupidly, in September 2019, Advocate General of the European Court of Justice, Gerard Hogan, found that disclosure of the documents would harm the companies' commercial interests and the cases were then awaiting a final judgment from the European Court of Justice.

In 2020, the two companies lost the case.[317] They were so arrogant that they had failed to give any concrete evidence of how the release of the contested documents would undermine their commercial interests.

After my success with EMA, I wanted to study cohorts of trial protocols for ongoing trials in Denmark to compare the information in protocols with the information provided to the patients to see if the trials were ethical and necessary.

Our request to see the protocols was turned down by several local research ethics committees. We complained to the national committee, which offered us full access provided we signed a confidentiality agreement stating we would not share commercially confidential information in the protocols with others. Despite this reassurance, several companies refused to provide their protocols and involved their lawyers. Sanofi-Aventis sued the national committee but lost the court case.

The protocols we had received before we got full access had many redactions. We could not identify any legitimate rationale for them. But they were most widespread in those sections of the protocol where there is empirical evidence of substantial problems with the trustworthiness of published drug trials: definition of the outcomes, data analysis, handling of missing data, detection and analysis of adverse events, interim analyses, premature termination of the study, ownership to the data, sponsor's access to incoming data while the study is running, and investigators' publication rights.[318] The parts of the text that were redacted differed widely, both between companies and within the same company.

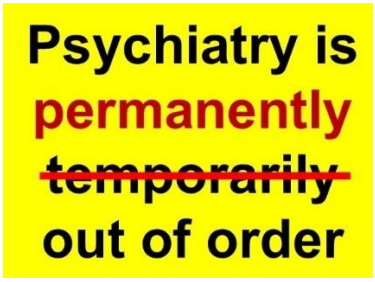
Clearly, the drug industry wanted to cover all tracks that could later be used to identify fraud when they had published the trials.

We used our cohort of protocols to investigate to what extent evidence from previous, similar trials or systematic reviews was considered before conducting new trials.[319] Only two

of our 67 protocols explicitly referred to a literature search. For eight protocols, our searches identified trials that could have been relevant to cite as justification for the trial.

We suggested that systematic literature searches should be required to ensure that the patients are not exposed to inferior treatments or unnecessary harms.

# 9 Psychiatry: a crime against humanity




In 2024, I summarised my 17 years of explorations into psychiatry in a freely available book - downloaded over 1000 times in the first three days after publication - where I explain why psychiatry is a crime against humanity.[320] According to the Rome Statute of the International Criminal Court, Article 7, crimes against humanity include murder, imprisonment, torture, persecution against an identifiable group, and inhumane acts intentionally causing severe mental suffering or serious bodily injury.[321] Psychiatric patients have often described forced treatment as imprisonment and torture, and they have reported that their ill-treatment is sometimes deliberate. Acadia Healthcare, a leading chain of psychiatric hospitals in the USA, often held people illegally and against their will to maximize insurance pay-outs while harming the patients.[322] This *is* a crime against humanity.

Psychiatric drugs kill so many patients that they are the third leading cause of death, after heart disease and cancer.[323] Most people take them for many years,[324] and some develop irreversible brain damage.[325] In the UK, mental health disability almost trebled in recent decades, and the gap in life expectancy between people with severe mental health issues and the population has doubled.[326]

One reason why psychiatry is so harmful is that almost all placebo-controlled trials of the drugs are flawed, and most Cochrane reviews and other systematic reviews of the trials are also flawed and not sufficiently critical.[327] Furthermore, when the results are negative, there is often spin on the results, which gives the readers the impression that the drugs are effective nonetheless.[328]

In most trials, the patients were on a drug like the one being tested. When they are randomised to placebo, some develop withdrawal symptoms that often mimic disease symptoms. Thus, the new drug outperforms placebo when placebo patients have been harmed.

The lack of blinding is also important. Because of the conspicuous side effects of psychiatric drugs, the blinding is broken for some patients, and the small differences recorded on a rating scale can easily be explained by this bias.[329]

Because of the flawed methodology, drug companies can show that their drugs “work” for virtually everything, and investigators can report positive effects that only exist in their imagination.

Drug agencies should not have approved psychiatric drugs based on flawed evidence. But they don’t care. My research group documented that their guidelines are deficient.[330] They recommend trials of short duration, with restricted trial populations, allow previous use of the drug, and often recommend rating scales for efficacy outcomes.

To find out for how long patients should continue taking their drugs, so-called maintenance studies, also called withdrawal studies, have been carried out. They are highly misleading because of cold turkey effects. A meta-analysis of 65 placebo-controlled trials found that only three patients needed to be treated with psychosis pills to prevent one relapse

after one year, but the apparent benefit of continued treatment with the pills decreased over time and was close to zero after three years.[331] When follow-up is longer, it turns out that more patients with schizophrenia recover when they discontinue their drugs.[332]

Please pause and think. Why would drugs that have no clinically relevant effects when used for acute psychosis (see below) suddenly have dramatic effects on relapse when they are withdrawn? It makes no sense.

All psychiatric drugs impair higher brain functions, which is what makes us human - our abilities to think, feel, function, remember, love, have empathy, and care for ourselves and others. Many drugs can cause permanent brain damage, loss of sexual function, and horrible abstinence symptoms when patients try to get off them.[333] When we looked at permanent brain damage in animals, we included 33 studies. But we were unable to publish our results, even in medical journals that publish systematic reviews of animal research. We were told the studies were of poor quality. This is true, but our review is helpful for researchers planning to do similar studies, and we therefore published it on my website.[334]

Some of the drugs that have been most widely used are also some of the most harmful ones, e.g. olanzapine, fluoxetine, paroxetine, and alprazolam. This is because most leading psychiatrists are corrupt.[335] Psychiatrists collect more money from drug makers than doctors in any other specialty; those who take the most tend to prescribe psychosis drugs to children most often; and they are also "educated" with industry's hospitality more often than any other specialty.[336]

My interest in psychiatry started in 2007 when midwife Margrethe Nielsen from the Danish Consumer Council wanted to find out if history was repeating itself. We found that the withdrawal symptoms were very similar for depression drugs and benzodiazepines, but they were described as dependence only for the latter.[337] This is irrational, but when Danish Lundbeck, a major seller of depression pills, was interviewed about our findings, they called it nonsense that people could become dependent on them.[338]

This denial is still prevalent. In 2020, Maryanne Demasi and I found that most websites state that SSRIs are not addictive.[339] Many leading psychiatrists, e.g. the former chair of the Danish Psychiatric Association, Jeanett Bauer,[340] say the patients are not dependent because they don't crave higher doses. Well, then smokers are not dependent on nicotine because they don't increase their daily consumption of cigarettes, right? But laypeople consider the pills addictive.[341] When patients try to stop, they often become worse than they were before they started on the drug.[342] That's what *addictive* means to most people.

Margrethe did three good studies, but two of her PhD examiners had turfs to defend, Steffen Thirstrup from the Danish Drug Agency and general practitioner John Sahl Andersen, who rejected her thesis. The third examiner, psychiatrist David Healy, disagreed. This caused a delicate problem, and the university phoned me. We decided to treat the rejections, which were wholly unconvincing, as peer reviews and Margrethe defended her thesis successfully.

We showed that when the use of benzodiazepines declined, it was compensated by a similar increase in the use of SSRIs.[343] Later, Olivia Dinnage and I showed that there had been a similar explosion in dubious indications for SSRIs as we saw for benzodiazepines and before that for barbiturates. Over 200 diagnoses had been investigated in placebo-controlled trials.[344] We concluded that depression pills are the modern version of Aldous Huxley's soma pill intended to keep people happy in *Brave New World*.

Science journalist Robert Whitaker from Boston has inspired me more than anyone else in this area. I met Bob for the first time in Copenhagen in 2012 where he lectured and showed that psychosis pills do more harm than good.

I was sceptical as it went counter to my training. But when I had read Bob's two outstanding books[345] and a lot else, I knew he was right. He was severely punished for telling the truth about how harmful psychiatry is. After his first book, *Mad in America*, he was banned from writing about psychiatry for magazines.

*Anatomy of an epidemic* won the Investigative Reporters and Editors book award for best investigative journalism, but as soon as it came out, he was treated as an outlaw. The *Boston Globe* ran a review by a doctor who accused Bob of doing great harm.[346] After that, Bob had radio interviews cancelled, and no other major newspaper reviewed the book. The reviewer was paediatrician Dennis Rosen whose department was a big recipient of pharma grants, and he worked closely with corrupt Harvard child psychiatrists. Rosen said Bob's book was dangerous. Yes, it was dangerous for psychiatry as a profession, but the psychiatrists were dangerous for their patients.

When Bob's book came out in Danish,[347] psychiatrist professor Poul Videbech wrote in an industry-funded magazine that Bob wants to prove the thesis that psychiatric treatments make people sick, and he claimed that Bob had quoted all studies that speak in favour and ignored all that speak against: "The author, who is a journalist, cannot of course familiarise himself more closely with the original scientific literature."[348] Videbech's arrogance was even apparent in the title: *The boy has no clothes.* Under the heading, *It is the emperor who is naked*, general practitioner Herluf Dalhof delivered a crushing criticism of the emperor's (Videbech's) disparaging review of Bob's book, which he called ground-breaking.[349]

Bob's approach was systematic. He set out to investigate what psychiatric drugs do to people, not to prove a preconceived thesis, and he searched meticulously for any study that showed that psychiatric drugs improve long-term outcomes. There is none. All the long-term studies that exist tell a story of serious drug harms.

In the *New Scientist*, a UK physician said that Bob's book was consistently based on evidence, with astonishing intellectual punch, and was frighteningly persuasive.[350]

Bob and I became close friends. Given my scientific reputation, it meant a lot to Bob that I had approved of his work. Like other great people, Bob is kind, honest, and generous, and he always replies promptly to emails, no matter how busy he is. He is far better than most psychiatric professors in dissecting a piece of research and concluding if it is true or false, and he is also a much better lecturer.

The ugly censorship Bob was exposed to is one of the reasons why he started the *Mad in America* website in 2012. Censorship is also why I have published over 50 articles and two of my books[351] on this site. *Mad in America* has six million unique visits every year,[352] and there are affiliated organisations in many countries. The importance of Bob's leadership is phenomenal. Many patients have told me that our books and articles have helped them get the courage to abandon their "career" in psychiatry and to taper off their drugs, discovering that a life without drugs is much better.

**Facebook's absurd censorship and indifference to murder scenes**

Facebook is harmful for public health.[353] Its algorithms remove routinely the boosting of reports from Bob's science team and once, his science editor not only had his Facebook ad account revoked; he was permanently banned. Mysteriously, this ban was later removed.

During five weeks in the autumn of 2020, Facebook prevented boosting of several highly relevant messages about discrimination and causes and treatment of psychological distress. It is particularly worrying that Facebook, a US company, prevented boosting of two articles addressing racism. When they published the science review, *Heavy cannabis use linked to psychosis and cognitive deficits*,[354] Facebook disabled their ad account, saying they would no longer be able to boost any posts. I got particularly angry when the article, *Researchers: Antidepressant use in children increases suicide, no evidence of benefit*, was rejected by Facebook, then upon review accepted, then rejected again, then upon another review accepted again.[355] All over the world, psychiatrists and other doctors prescribe depression pills to children even though they don't work and double suicides (see below).

Facebook also blocked the mention of a very important book,[356] written by one of the best child and adolescent psychiatrists in the world, Sami Timimi. His book was serialised on *Mad in America* for free, and it is a masterpiece that can help hundreds of millions of psychiatric patients and their loved ones to get a better life.

Facebook has known for years that it is failing miserably to control hate speech on its platform, but they have hidden this from investors, politicians, and the public.

Facebook does not even act appropriately when a brutal murder scene is shared.[357] In December 2018, 24-year-old Louisa Jespersen from Denmark was trekking in Morocco with a Norwegian female friend, Maren Ueland. They were attacked in their tent by Islamic State terrorists and decapitated. The murderers filmed it all and distributed the video on Facebook. It arrived many times to Louisa's mother and sister, and on Louisa's Facebook page.

Anonymous senders were involved and there were often hateful comments, e.g. "She died as an idiot;" "If she had used her head, she would not have lost it;" and "I have seen the video where they kill her and it is very entertaining."

Several Danes received prison sentences for sharing the video. Jespersen contacted Facebook many times. Sometimes, the video was taken down. Then it came up again. Facebook could stop it permanently from being shared but didn't do this.

Jespersen reported a user who had uploaded a photo of Louisa's bloody body to Facebook and a photo a person had uploaded on her daughter's profile where Louisa's head is being cut off. Facebook didn't do anything. The photo didn't violate Facebook's guidelines, they said. Are they completely mad? For Facebook, it is worse seeing a nipple from a breastfeeding mother (see page 97) than seeing a brutal murder. They wrote:

"We understand that you do not like it. We recommend you hide the commentary, annul the friendship, or block the person who uploaded it."

What about showing a little respect for the grieving mother?

The EU has led the way globally about data protection and privacy rules, and this caused Zuckerberg in February 2022 to threaten to shut down Facebook and Instagram in Europe.[358]

Please, Mr. Zuckerberg, do us a favour, will you? Shut down all your activities, not only in Europe, but in the whole world.

**Laura Delano, a psychiatric survivor**

In 2013, Bob invited me to lecture at the Safra Center for Ethics at Harvard University, to which he belongs. I met with Marcia Angell, previous editor of *New England Journal of Medicine*, who has described how deeply corrupt American psychiatry is.[359]

I have lectured with Bob in the USA, Denmark, Norway, Sweden, Australia, and New Zealand. Every time, there were psychiatrists in the audience who agreed with us that the way we use psychiatric drugs causes far more harm than good.

In 2014, we lectured in Los Angeles at the annual conference of the International Society for Ethical Psychology and Psychiatry. The press release announced that the speakers shared the belief that the medical model of psychiatric care - that distress and misbehaviour have physical causes that are best treated with drugs - is harmful. The meeting was fascinating and the lectures are available.[360]

The organiser, psychologist David Cohen, gave me the Society's award for "Intellectual honesty and bravery in tackling the biomedical-industrial complex." He said that 50 years of increasingly sophisticated treatments had increased the burden of mental disorders. Bob has shown that the rate of disability pensions follows the usage rate for depression pills closely in all countries he examined, and that after SSRIs came on the market, a 35-fold increase in disabled mentally ill children in the USA was seen in just 20 years.[361]

If psychiatry had been a business, it would have gone bankrupt decades ago, but the lies to make it survive have been brutal. The public has been told a story about reforms, revolutions, progress, innovations, and paradigm shifts. I have heard numerous stories from patients who said they had no idea how dangerous it was to become a psychiatric patient and trusted their doctors, until they found out years later that their lives had been ruined.

The speakers in Los Angeles included leading psychiatrists, e.g. Allen Frances and David Healy, and a previous patient, Laura Delano. She calls herself a psychiatric survivor, which says it all. In no other medical specialty do the patients call themselves survivors in the sense that they survived *despite* being exposed to that specialty. In other specialties, the patients survived *because* of the treatments their doctors applied to them. Laura noted how people support each other in coming off psychiatric drugs, de-indoctrinating themselves from the false biomedical model of mental disorders,[362] which posits they are brain diseases caused by specific biological abnormalities that can be corrected by drug treatments.

Bob's second book saved her. She was on five drugs; had become dehumanised by psychiatry; and was called treatment-resistant. Even her drug-induced weight increase had a psychiatric diagnosis: binge eating. She reclaimed her humanity and freed herself from the prison of psychiatric "care." After she dropped the drugs, she was completely normal.

Laura and I lectured at a meeting at the World Congress in Psychiatry in Berlin in 2017, arranged by Peter Lehmann, a German reformer. When I spoke about withdrawal from psychotropics, there were around 150 psychiatrists in the audience, and the atmosphere was hostile. Some people asked irrelevant questions, e.g. if I didn't believe that lithium worked, even though I had not discussed this drug at all.

Fifteen minutes later, I gave a talk about why psychiatric drugs kill so many people. Three psychiatrists out of the over 10,000 participants at the congress attended. They refused to give interviews and carefully avoided being filmed by the documentary film team that followed me, as if they were on their way to see a porn movie!

Helle and I celebrated Laura's wedding north of Göteborg in June 2022. It was the first time during the COVID-19 pandemic we behaved as before the pandemic, hugging people and kissing the beautiful bride – as they say in America: "You may now kiss the bride." Like many other guests, we came home with the virus made in China,[363] even though we had been vaccinated twice.

**Misleading drug names, doubtful diagnoses and erroneous textbooks**

Already the names of the drugs are deceptive.[364] Antibiotics can cure infections, but antipsychotics cannot cure psychosis, antidepressants cannot cure depression, and anti-anxiety drugs cannot cure anxiety. In fact, these drugs can *cause* psychosis, depression, and anxiety, particularly if used long term and when people try to come off them. And there is nothing selective about selective serotonin reuptake inhibitors. There are serotonin receptors throughout the body, and the drugs have many other effects than increasing serotonin.

The indoctrination starts with the students. In 2022, I read the five most used psychiatric textbooks in Denmark[365] to see what students are taught at our universities. I described what is wrong in my freely available *Critical psychiatry textbook*.[366] The textbooks contain a litany of erroneous statements about the causes of mental health disorders, if they are genetic, if they can be detected in a brain scan, if they are caused by a chemical imbalance, if psychiatric diagnoses are reliable, and what the benefits and harms are of psychiatric drugs and electroshocks. Many of the claims are scientifically dishonest, and fraud and serious manipulations with the data were common in often-cited research. Sometimes there were contradictory messages within the same book, and logical thinking was scarce.

I have published many scientific articles and four books about psychiatry,[367] have given numerous lectures and interviews, and have been an expert witness in court cases about medical malpractice in Brazil, Canada, USA, Ireland, Denmark, Norway, Sweden, Holland, Australia and New Zealand, often related to psychiatry. I have noticed that leading psychiatrists, also in court, have no problem with claiming the opposite of what the most reliable science shows, which makes them - sorry for being blunt - habitual liars.

I had seven PhD students in psychiatry. They produced unique research results of great benefit to patients, but psychiatric leaders disliked them. As they had no valid arguments, they resorted to *ad hominem* attacks and often lied about our research.

The diagnosis is the entry ticket to a psychiatric "career." Creating many diagnoses means big business, fame, and power.[368] The diagnostic criteria are constantly being lowered, creating more customers, e.g. a quarter of the US population in 2012,[369] and they are vague and unreliable.[370] There was close to nothing in the textbooks about that psychiatric diagnoses are based on arbitrary criteria; that there is large interobserver variation when several psychiatrists assess the same patients;[371] that most healthy people can get several diagnoses if tested;[372] and that no one can live a normal life without getting symptoms compatible with a psychiatric diagnosis, which is why screening for mental health issues is a very bad idea.

Tautologies – circular evidence – were common. Shockingly, one textbook noted that the diagnosis is conformed or rejected based on the treatment results. Well, most people improve without any treatment! The WHO has stated that depression "can cause the affected person to suffer greatly and function poorly at work, at school and in the family."[373] This is also a tautology. We cannot blow life into something that is just a name. A description of a cluster of symptoms cannot cause anything. If a patient is feeling low and the psychiatrist replies that this is because she has depression, it is also a tautology. Low mood and depression are synonymous.[374] A classification can only *describe*, not *explain*.

There was very little information in the textbooks that environmental factors are important for mental health. Unemployment, poverty, trauma, and other psychosocial issues are major risk factors for depression.[375] People are not attacked by some psychiatric monster

called depression[376] but can become depressed if they live depressing lives, e.g. are married to the wrong person, have a bullying boss, a tedious job, no job, or a chronic disease.

There is much overlap in the criteria for different diagnoses, which gives many patients a "comorbidity" label, although they don't have several "diseases." Some prominent psychiatrists have admitted that psychiatric diagnoses are not discrete illnesses but constructs.[377]

At a fabulous *Too much medicine* meeting in Helsinki in 2018, the organisers had invited those speakers they thought were the most interesting ones world-wide. We discussed diagnoses, and I joked that having a diagnosis is not the same as suffering from it:

"Does Donald Trump suffer from a mental disorder?"

"No, he enjoys it, but everyone else suffers!"

Allen Frances also lectured and spread my joke to the whole world on Twitter. Unfortunately, Trump is now president again, behaves like an unaccountable king, and has rapidly made the whole world suffer.

Psychiatry has become dehumanised and industrialised. Find x faults with the patient out of y and you have a diagnosis and a drug. You don't need to waste time talking with patients to find out what happened to them and how you might best help them.

In the spirit of the thinking behind the US Diagnostic and Statistical Manual of Mental Disorders (DSM), I invented a diagnosis for healthy people: Adult Symptom Deficiency Disorder (ASDD).[378] I was inspired by a cartoon by Randy Glasbergen in which a doctor tells a patient, "We can't find anything wrong with you, so we're going to treat you for Symptom Deficit Disorder." There are 10 questions and all scores lead to a treatment option.

**The lie about the chemical imbalance**

To convince patients to take drugs they don't need and don't like because of their adverse effects, or are afraid of, psychiatrists have invented the lie that their disorder is caused by a chemical imbalance in the brain, and that a drug will fix it.[379]

Research has never demonstrated a chemical imbalance being the cause of depression[380] or any other mental disorder. But some leading psychiatrists even lie about their lies. US professor Ronald Pies described chemical imbalance as an "urban legend, never a theory seriously propounded by well-informed psychiatrists" and blamed the legend on "opponents of psychiatry" who "mendaciously" attributed it to psychiatrists.[381] What a lie.

In 2013, Danish depression icon Poul Videbech said that advising people to stop taking their antidepressant was like advising patients with diabetes to drop their insulin.[382] A year later, he said that psychiatric disorders are not caused by an imbalance in the brain,[383] but eight months later, at a large meeting arranged by medical students where he and I debated, he said: "Who would take insulin from a diabetic?" In 2015, when my first psychiatry book came out,[384] Videbech called it totally off limits that I wrote that he and others believed in the chemical imbalance.[385] But psychiatry professor Birte Glenthøj was also interviewed and said: "We know from research that patients suffering from schizophrenia have on average increased formation and release of dopamine, and that this is linked to the development of the psychotic symptoms."

I explained what was wrong.[386] If a house burns down and we find ashes, it doesn't mean the ashes set the house on fire. And if a lion attacks us, we get frightened and produce stress hormones, but it wasn't the stress hormones that made us scared. People with psychoses have often suffered traumatic experiences in the past,[387] so if they have a "chemical imbalance," it is the result of the psychosis rather than its cause.[388]

In 2015, Psychiatry in the Capital Region held a large meeting at my hospital with the title, *Falsehoods and truths about psychiatric drugs*.[389] The occasion followed a prolonged debate about psychiatric drugs I had started a year earlier, and the chair started with a long introduction about the ten myths I had described (see page 198), including the one about the chemical imbalance,[390] but without mentioning my name. A former patient asked why he who had started the debate was not an invited speaker. Psychiatrist professor Lars Kessing replied that people would not be able to follow a scientific debate between professors. But if the audience could follow three professors' presentations and discussions, they could probably also follow a discussion between four professors.

Officially, the aim of the meeting was to provide "a neutral and sober assessment of the drugs," but its true purpose was to protect the *status quo*.

Kessing delivered many falsehoods, e.g. that depression drugs prevent depression and don't increase the risk of suicide in young people, and that you don't become dependent on them - even though his own study of patients' experiences had shown exactly this.[391]

Merete Nordentoft launched two horrible falsehoods: That patients with schizophrenia live longer when they take antipsychotics and that only 3% relapsed in the first year on drugs, while 77% relapsed when the medication was discontinued.

Kerstin Plessen's falsehoods included that ADHD can be seen in a brain scan and is strongly hereditary, and that ADHD drugs improve social functioning, reduce the risk of crime, and possibly also reduce substance abuse.

Ironically in the extreme, all three professors made the meeting one of falsehoods, and he who could tell the truth wasn't invited.

Noting that the chemical imbalance story was dead in other countries, psychologist Olga Runciman asked if it was also dead in Denmark. None of the professors replied, and the chair didn't hold them to account, not even after I had said twice that they hadn't replied.

Jens Peter Dam Eckardt Jensen, chief analyst at the patient association *Better Psychiatry*, was honest. He mentioned a study of the relatives' views on psychiatric drugs:

Only one in five are confident that mentally ill people are treated with the correct medication and that the staff react in a timely manner if the patient experiences side effects; three of four are worried about the patient's state of health because of the medication; one in two have experienced that the patient has been given the wrong combination or dose of medicine; four of five believe that drugs are used too much compared with other forms of treatment; and one in five have been concerned that the drugs are life-threatening.

Eight months later, I emphasised in an interview that many patients end up taking drugs for the rest of their lives because they have been fooled by the chemical imbalance lie or by being told they will become brain damaged if they don't take the drugs.[392] Psychiatrist Lars Søndergård said he didn't know of any psychiatrist who attributed mental illness to a chemical imbalance,[393] which another psychiatrist, Julius Nissen, contradicted.

In 2017, Videbech postulated again that depressed people have an imbalance in the brain, on the website of the Psychiatry Foundation.[394] In their two articles in the web-based Handbook for Patients, he and Kessing both claimed this.[395] I complained to the editor four times[396] but got nowhere. They changed a few minor things and introduced new claims that made their articles even worse. They now wrote, without references, that antidepressants stimulate the brain to make new nerve cells. If true, it would only mean that the pills harm the brain, as it makes new cells in response to a brain injury.[397] I complained again, and again to no avail, and the lie about the chemical imbalance continued.

This lie won't go away. In 2019, Maryanne Demasi and I found that 74% of popular websites attributed depression to a chemical imbalance or claimed that drugs could correct such an imbalance.[398] Even in 2022, hospital-based psychiatry in one of the five regions in Denmark mentioned the chemical imbalance in relation to schizophrenia, depression, affective disorders, and AHDH on its homepage,[399] and the official website for health, sundhed.dk, mentioned it in relation to depression.[400]

When I said in my lectures for psychiatrists that many patients have been told they have a chemical imbalance, I was met with angry responses demanding that I document my allegations. When I told them of surveys of patients' experiences, they argued that these were just anecdotes, not been published in a peer-reviewed journal, which was false.

In 2025, I notified the UK drug regulator, the Medicines & Healthcare products Regulatory Agency (MHRA) that the package inserts for antidepressants – called patient information leaflets (PIL) - contain false statements about depression being caused by a chemical imbalance. Two months later, the MHRA replied, and one of my colleagues said that "This is the biggest bullshit response I have ever read." Their arguments were void[401] and they preferred to continue lying to the patients rather than helping them understand that there is nothing wrong with their brains and that they do not need to take the pills for the rest of their life to correct a non-existing chemical imbalance.

## What psychiatry should be about: psychosocial interventions

The WHO and the United Nations recently called for systematic mental health reform emphasising psychosocial interventions instead of drugs.[402] Psychiatry needs to be completely restructured, respecting informed consent, and making forced treatment - which kills many patients - illegal.

Psychotherapy and other psychosocial interventions should be the treatment of choice for patients suffering from mental health issues. Taking an interest in the patients and their family can be more important than anything else. It can change the way people view themselves, their surroundings, their past and future, and how they interact with other people.

In 2019, a Norwegian study found that 52 of 100 consecutively admitted patients to a psychiatric hospital would have wanted a drug-free alternative if it had existed.[403] Why can't people then get psychosocial interventions instead of drugs? Because psychiatry is a perverse trade that doesn't help the patients as they want to be helped and would best be helped but helps itself, at great cost for society. The disrespect for patients is enormous. Most patient's views - which agree with the most reliable science we have - are that they become mentally ill because something untoward happened to them.[404] And when laypeople were asked what sort of treatment they would prefer, six times as many preferred psychotherapy for pills.[405] However, in the USA, the average psychiatric resident gets no psychotherapy training.[406] In Sweden, the Board of Health recommends that by far most people with depression should be offered psychotherapy, but only 1% get it.[407]

After having experienced the benefits of involving the family, a young psychiatrist, Maria Grazia Turri, set up a Systemic Assessment Clinic (SAC) with another psychiatrist where they asked referred patients to bring along anyone, they felt was significant to their lives.[408] This made it easier for them to find out what the patients' problems were, and the patients and their carers were highly satisfied with the process.

However, their many attempts at getting support or endorsement of the SAC from the local NHS Trust failed. They were told it was not evidence-based and were encouraged to

apply for a grant. They pulled together a team of eight experts and used a whole year to write a 56-page grant application, which was rejected.

They then compared the outcomes for 22 SAC patients with 22 similar patients assessed in a standard fashion during the same period. Only one patient was re-referred in the SAC group versus nine in the control group. Engaging people in meaningful conversations made it possible to develop a recovery-oriented plan while the standard approach tended to make the patients chronically ill, as also documented by Bob Whitaker.[409]

Turri sent a paper to the *Bulletin*, published by the Royal College of Psychiatrists. It was rejected without peer review. She appealed, and a member of the editorial board enthusiastically replied that the paper should be sent for peer review. The reviewers were positive and suggested some revisions. She resubmitted and was told by the reviewers that her paper could now be published. However, the editor refused saying he didn't believe the validity of the data, which is an appalling poor excuse for rejecting an important paper.

Turri contacted the President of the Royal College of Psychiatrists who replied that the editor's opinion should be upheld and advised her not to waste any more time and energy on the matter.

Turri's story is typical. The psychiatric paradigm is so harmful for the patients that leading psychiatrists need to protect their specialty by censoring unwelcome data. It took five years after the first submission before Turri's study got published.[410]

What is most important is that the therapist is a good listener and meets the patient where that person is, as Danish philosopher Søren Kierkegaard advised us to do two centuries ago.

Most problems patients face are caused by maladaptive emotion regulation, and psychiatric drugs make matters worse, as their effects constitute maladaptive emotion regulation. In contrast, psychotherapy aims at teaching patients to handle their feelings, thoughts and behaviour in better ways, which is adaptive emotion regulation. It may permanently change patients for the better and make them stronger.

Psychiatric drugs change the brain into an artificial third state - an unknown territory - that is neither normal nor the malfunctioning state the patient came from.[411] This is problematic because you cannot go from the chemically induced third state back to normal unless you taper off the drugs, and even then, it will not always be possible, as the drugs might have caused irreversible brain damage.

Psychotherapy can be difficult when the patients are drugged, which may render them unable to think clearly or to evaluate themselves. The lack of insight into feelings, thoughts and behaviours, called medication spellbinding,[412] causes the patients to underestimate the harms of the drugs and to overestimate their benefits.

Studies with long-term follow-up show that psychotherapy has an enduring effect that outperforms drug therapy.[413] And a huge network meta-analysis found that pills do not add anything to the effect of psychotherapy in patients with depression.[414] But the authors were not honest.[415] They implied, despite their negative findings, that the combination has merit and failed to inform their readers that pill treatment can be fatal. Depression pills double the risk of suicide[416] whereas psychotherapy halves this risk,[417] but a textbook claimed that the preventative effect of drugs against suicide is better than that of psychotherapy.[418] Psychotherapy is useful for most psychiatric disorders, even psychoses.[419]

I have met psychiatrists in several countries who don't use psychiatric drugs. They treat even severely disturbed patients with empathy, psychotherapy, and patience,[420] which is rational because physical and emotional pain are similar. We need physical pain to avoid

danger, and we need emotional pain to guide us in life. Åsa Nilsonne, professor of psychiatry at Karolinska Institutet, doesn't use drugs. She argues that non-drug treatment allows patients to learn something important through the process of healing that can boost their self-confidence and be useful if they get in trouble again.[421]

Åsa has also noted that doctors may think they need not engage themselves as much when a patient is taking drugs, as they believe the drug will do the work for them. When my first book about psychiatry came out in Swedish, my publisher arranged two well-attended public meetings in Stockholm in 2016 where Åsa was chair. There were a few highly aggressive psychiatrists in the audience but they lost the debate. They didn't challenge the arguments presented in my book but provided misleading information, which included that depression drugs protect against suicide.

The psychiatric textbooks showed that psychiatrists have absolute power over everything in mental health, and that psychologists and other professionals are left to the sidelines. There wasn't much mention of an independent role of psychologists. Psychotherapy was often listed as an option, but almost always in a context that also involved drugs, and it was implicitly understood that psychotherapy was the responsibility of psychiatrists.

When psychologists were mentioned, their role was limited to administering psychological tests, including projective personality tests such as the Rorschach test, which involves showing the patients a series of inkblots and asking them to explain what they see in those figures. Oddly, this display of power was particularly clear in the textbook about child and adolescent psychiatry,[422] even though psychotherapy and other psychosocial interventions have a stronger standing in children than in adults. There was nothing about how psychologists could help children, and there was a pleonasm: If a person has a mental disorder, there is psychopathology suggesting a psychiatrist is needed. It is just another name for the same thing.

What is important for children is to assist and support them learning essential social and emotional skills to manage their behaviour better and to improve their ability to adjust to their surroundings. Finnish psychiatrist Ben Furman has developed a fascinating programme, Kids'Skills,[423] which does this and make kids with difficulties proud of their achievements.

In the textbooks, most psychologists agreed with the psychiatrists, and they were sometimes even more radical and uncritical, e.g. in their praise of what brain imaging studies can tell us about psychiatric disorders and of drug effects. In a radicalised group, newcomers tend to be even more radical than their leaders to become accepted as their equals. Fringe groups therefore tend to become more radical with time. Furthermore, often supported by their scientific associations, some psychologists want to get permission to prescribe drugs and they will not succeed if they are seen as critics of mainstream psychiatry.

The textbook, *Clinical neuropsychology*, which has three psychologists as editors, illustrates this.[424] Three pages describe imaging studies in depression, with many references, which conveys the false message that we know a lot about the brain, based on reliable studies. We know next to nothing.[425]

The textbooks recommend psychotherapy for mild or moderate depression whereas severe depression is to be treated with pills and electroshock.[426] This is a familiar, yet absurd, theme. The worse the disease, the more the patients shall be harmed by harmful treatments. One book focused totally on pills, for all severities of depression, and psychotherapy was only a means aimed at keeping the patients on pills!

A chapter on psychotherapy written by professor of psychology Nicole Rosenberg was unusually well documented. She wrote that cognitive behavioural therapy has large effects

for generalised anxiety, social phobia, and post-traumatic stress disorder (PTSD) and can prevent relapse and get depressed people back to work.[427] Depression pills have the opposite effect. The rate of disability pensions follows the usage rates for depression pills.[428]

One textbook noted that psychotherapy was cost-effective compared to drugs in many cases. Yes, but not only in many cases. Psychotherapy *is* more cost-effective.[429]

At a PhD defence in Copenhagen in 2022,[430] one of the examiners, psychologist Ole Jakob Storebø, made a lot out of saying that psychotherapy wasn't better than drugs for depression. I remarked that this wasn't correct and that drugs double the suicide risk whereas psychotherapy halves this risk.

Storebø didn't reply, but the other examiner, psychiatrist Christopher Baethge, said that psychotherapy doesn't always work and when the patients came to him, they had already tried it in vain. Maybe so, but this cannot justify using harmful pills.

In 2015, I participated in a panel at a conference with hundreds of patients in the auditorium. After I had advocated for psychotherapy instead of drugs, also for patients with schizophrenia, the psychiatrist on the panel, Professor Merete Nordentoft, remarked that drugs could not always stand alone. I said that everyone should get psychotherapy and that this could not always stand alone. The audience applauded. Many patients hate psychosis pills but are forced to take them.

## Depression: pills don't work and cause suicide and homicide

The lies about depression pills are gigantic. The US National Institute of Mental Health (NIMH) has claimed that the pills lower mortality,[431] but they increase mortality.[432] Their main effect is to ruin people's sex lives,[433] but in the upside-down world of psychiatry such pills are called happy pills. I call them unhappy pills or anti-sex pills.[434]

The sexual harms can become permanent, and when the patients find out that they will never again be able to have sex, e.g. because of impotence, some kill themselves.[435] Rats can also become permanently sexually impaired,[436] which we confirmed in a systematic review of animal studies.[437] We tried to study other irreversible harms, but there were too few studies.[438] All the authors concluded that the drugs were not beneficial in the long term.

When I lectured for Australian doctors in 2015, a child psychiatrist said he knew three boys on depression pills who had attempted suicide because they couldn't get an erection the first time they tried to have sex. It is so cruel.

The American Psychiatric Association's disease manual, DSM-5, states that major depression is present when the patient exhibits at least 5 of 9 symptoms that "cause clinically significant distress or impairment in social, occupational, or other important areas of functioning." Given how the disorder is defined, it makes no sense that drug trials don't use such outcomes. Over a thousand placebo-controlled trials have been carried out, but I have not seen any that reported if depressed patients came back to a normal productive life.

The effect is assessed on meaningless rating scales. To claim that a reduction of symptoms of emotional pain on a rating scale is proof of efficacy is like claiming that aspirin can heal a broken leg because it reduces physical pain. A score on a scale cannot tell us if the patient is well. The Hamilton depression scale contains symptoms like sleeping difficulties, anxiety, agitation, and somatic complaints, which may improve with alcohol and opioids, which we do not call antidepressants. Using this scale, even cocaine, ecstasy and amphetamine would seem to work for depression. Almost everything could.[439]

Depression pills don't work for depression. In industry-sponsored placebo-controlled trials, the difference between drug and placebo was only 2 on the Hamilton scale,[440] and the smallest effect that can be perceived is 5-6.[441] This clear message was not welcomed. Eskild Colding-Sørensen from the Danish Drug Agency claimed that a 2017 Danish meta-analysis that found this[442] - the best ever - bordered on irresponsibility. The agency concluded that the meta-analysis did not provide any new knowledge and that there was no reason to change recommendations or information about the drugs. This made us publish the article, *Does the drug agency work for patients?*[443] If there was no new knowledge, then why had the agency approved the ineffective and harmful drugs in the first place?

Colding-Sørensen headed the agency's report, and they did not consider it a problem that he had a leading position in Lundbeck from 2010 to 2015[444] because he had not worked with depression pills. Referring to this peculiar logic, we noted that if the authorities hired a leader from Volkswagen to investigate the scandal about Volkswagen's fraudulent measurements of exhaustion gases from diesel oil, this wasn't a problem if he had worked with gasoline vehicles in the company. The agency's director, Thomas Senderovitz, who came from Grünenthal, the company that sold thalidomide, announced months before the investigation what the conclusion would be. He said the meta-analysis concluded something the data could not sustain, which was totally false.

Other people were also the industry's useful idiots. Chairman for the Danish Society for General Medicine, Anders Beich, opined that the researchers had published their results selectively, which was absurd, as they had done a systematic review including *all* trials. He also claimed there was no basis for the conclusions.[445]

The director of the Board of Health, Søren Brostrøm, talked about the lack of nuance, which had made patients worried. They surely should be worried if they took such drugs!

Henrik Ullum, chair of the Danish Medical Societies, attacked us with strawman arguments.[446] We had not accused Senderovitz of dishonesty or leaders in the drug agency for having conflicts of interests, which was a fact. It was pathetic that Ullum noted that I had published a book that "accuses" the drug industry of "being the globe's worst criminal league on par with the mafia." This is also a fact (see chapter 7). Ullum's view – that we had "accused" the drug agency for an embarrassing practice with no documentation – was also false, as we had provided plenty of documentation.

In an industry-funded magazine, psychiatrist Maj Vinberg characterised the Danish meta-analysis as "a smear campaign against antidepressant drugs ... doubtful populistic discussions ... armchair gymnastics ... performed by a group … without special knowledge about psychiatry and depressive disorders." Some of the authors were my highly skilled employees. I responded to Vinberg's ravings,[447] quoting my 2014 article, *The meeting was sponsored by merchants of death*,[448] which included AstraZeneca, one of Vinberg's benefactors. The meeting was arranged by the Scandinavian College of Neuropsychopharmacology and the meeting announcement listed AstraZeneca and Janssen as sponsors, with their company logos on the front page, and with the text, "All sponsor grants are unrestricted," as if there was nothing to worry about.

I described in my book about organised crime that the meeting sponsors had recently paid over $1.6 billion because of their criminal activities that included kickbacks, illegal marketing of their psychosis pills, and lies about their harms. The successful bastards were promoted, just as in mob circles. Johnson & Johnson's board of directors rewarded Alex Gorsky, Vice President of Marketing, for his fraud by selecting him to be the next CEO.

Some researchers have noted that depression pills are more effective in severe depression, but the effect is irrelevant even in very severe depression, only 2.7,[449] and I have explained that it is likely just due to two mathematical artefacts that the effect seems to be slightly larger in severe depression.[450]

The psychiatric textbooks were highly dishonest about depression pills. They mentioned that 60-80% of the patients become healthy after 6-10 weeks but did not say that this is not a drug effect, but spontaneous remission. This false information also appeared in our medical journal, after I – much too kindly - had said on TV that the drugs help 10-20% of the patients.[451] The psychiatrists called my information "misleading," which in a way it was because the drugs don't work at all, and they criticised the journalists for having talked to me and not to a psychiatrist. Well, you don't ask a barber if you need a haircut.

In 2011, three psychiatry professors, Videbech, Kessing, and Raben Rosenberg, criticised TV for having mentioned that the effect of SSRIs is 20%, which they called misinformation. I explained that the criticism was unjustified. [452] The psychiatrists were dishonest, as they had themselves declared that the difference between placebo and active substance was 20%, and the TV channel replied that the information came from the Danish Medicines Agency.

Psychiatrists are unable to interpret the science[453] or deliberately mislead the public. When they – rarely – acknowledge that the pill effect is small, they say it isn't important because the patients will benefit from the large placebo effect. This is a common misconception. Doctors often think the placebo effect is the before-after difference in a group of patients treated with a placebo, which it isn't, as the spontaneous improvement is included. As we have shown, placebo effects are small, if any.[454]

Videbech noted that he had received money from virtually all drug companies in Denmark, but when a journalist asked him about a handbook for patients with depression he had written for Eli Lilly, he got so angry that he hung up.[455]

One textbook claimed that psychomotor speed, sleeping pattern, appetite, and mood become normalised, and that depressive thoughts about guilt, inferiority, and suicide vanish. These are blatant lies. Absolutely nothing becomes normal because of pill treatment.

When I mentioned on TV that depression pills can change a patient's personality, Jeanett Bauer, President of the Danish Psychiatric Association, and psychiatrist Jesper Karle, replied it was misleading to focus on a side effect that is extremely rare and scary for patients.[456] It is not rare. Six years earlier, Danish psychiatrists reported that half of the patients agreed that the treatment could alter their personality and that they had less control over their thoughts and feelings.[457] The psychiatrists refused flatly to believe what the patients had told them, called them ignorant, and felt they needed "psychoeducation." The problem with this was that the patients' relatives had the same opinion as the patients.

I criticised Bauer and Karle for their dishonest information that the drugs work for two-thirds of the patients and that the side effects are mild and transient.[458] In contrast to drugs, exercise works for depression.[459]

Brain scan studies play a major role when psychiatrists try to convince people that their drugs are necessary. The textbooks are full of extraordinary claims about what depression pills can accomplish.[460] But there are no references, and what is claimed is highly unlikely to be true, e.g. that the pills decrease brain damage, are neuroprotective, and prevent nerve cell death.

Brain imaging studies are grossly unreliable,[461] but Videbech has claimed that untreated depression leads to brain atrophy, and that drugs can reverse these changes.[462] He also

believes depression doubles the risk of dementia.[463] But the meta-analysis he cited did not mention which treatments the patients had received.[464] Other studies indicate that it is the drugs that make people demented.[465] In the *BMJ*, I disputed the claim that depression and anxiety are risk factors for Alzheimer's disease.[466] However, a PhD holder in psychopharmacology, Jesper Andreasen, also believed it is the disease that makes people demented and criticised me for not being a psychiatrist or an expert on psychiatric drugs.[467] Well, I have learned to read and understand what I read, which Andreasen hasn't because he believed psychiatric disorders are caused by chemical imbalances.

As depression pills have only small symptomatic effects and many harms, it is relevant to know what the patients think about them when they weigh the benefits against the harms. They do this when deciding whether to continue in a trial till the end or drop out.

As published trials are unreliable, we used the 71 clinical study reports we had obtained from drug agencies. I am convinced that no one outside my research group have read the 67,319 pages about these trials (18,426 patients), which amount to a stack 7m high if printed. We found that 12% more patients dropped out while on drug than while on placebo.[468] The patients preferred the placebo even though those who were randomised to placebo were exposed to cold turkey withdrawal effects when the depression drug they were already on was stopped. Thus, the drugs are even worse than what we found.

We also looked at quality of life, which we expected would be worse on pills than on placebo. But we had now come too close to the secrets of depression pills. The reporting of quality of life was virtually non-existent.[469] A huge amount of data was missing in the clinical study reports, and selective reporting of outcomes that happened to be positive was common. Despite this bias, we found only small differences between drug and placebo.

A politician I collaborated with asked the Minister of Health if it was trustworthy that the Danish Drug Agency emphasised that in some of the studies an effect on quality of life had been found, when only three out of 131 studies had published data on quality of life?[470]

The Minister replied that the Agency had pointed out that there was an effect on quality of life in the studies where this was measured and that this supported the clinical relevance of the pills. This reply was ultra-comical and irresponsible. We included 15 trials in our review of quality of life!

The amusement continued. The Minister said that "Concluding on clinical relevance as such requires nuanced considerations and the involvement of professional expertise. A number on a scale (such as Hamilton's depression scale, ed.) is not sufficient."

How come that "professional expertise" never involves asking the patients what they think? They don't agree with the psychiatrists that the pills are helpful for them.[471]

The textbooks recommended dose increases to obtain better effects even though the many dose-response studies of depression pills have not shown an increased effect of larger doses.[472] What doctors obtain by increasing the dose is to waste taxpayers' money and to increase the risk of killing their patients.[473]

The dream of a quick fix for depression never stops. The latest fad is esketamine, the S-enantiomer or mirror image of R-ketamine, a dissociative hallucinogen. In 2019, two psychiatrists praised esketamine in the *BMJ*.[474] I responded with some colleagues that a drug cannot possibly have a dramatic effect on depression within the first day of treatment unless something is terribly wrong.[475]

Psychiatrists often claim their drugs are highly effective by mentioning the number needed to treat (NNT) with a drug to benefit one patient. This is an illusion because more patients are harmed than those who benefit.[476] Since depression pills harm the sex life in half the patients,[477] the NNH is only two. Thus, by *not* using depression pills, we will preserve the sex life in one out of every two patients we do *not* treat.

**Rewarding the companies that cheated the most**

A 2018 network meta-analysis in *The Lancet* by Cipriani and colleagues[478] got enormous attention in the media.[479] We noted there was nothing new[480] - the drug effect was the same as in earlier meta-analyses - but the researchers called for the pills to be more widely used. They ignored entirely the data on harms, and their meta-analysis was so flawed that I wrote the article, *Rewarding the companies that cheated the most in antidepressant trials*.[481]

The authors included 522 trials comparing the drugs with each other or with placebo and most of the data came from published reports. They ranked the drugs according to their effect, which is absurd as none of them works, and drop-out for any reason. They claimed that agomelatine, escitalopram, and vortioxetine were more effective than other drugs and also better tolerated. As this is extremely unlikely, I took a closer look at the three drugs.

Astonishingly, a review of agomelatine - which Cipriani co-authored - found no effect even though none of the negative trials had been published.[482] It is also far-fetched to believe that escitalopram can be better than citalopram. The active ingredient is the same. When studied by Lundbeck in head-to-head trials, and meta-analysed under Lundbeck's control, the active molecule is better than itself.[483] But all three authors worked for Forest, Lundbeck's American partner, and the paper was published in a bought supplement to a journal edited by the first author. Four independent reviews, including one by the FDA, concluded that escitalopram is not better than its mother molecule,[484] which independent researchers confirmed.[485]

Lundbeck launched escitalopram when the patent for citalopram expired and earned a lot of money via a huge fraud scheme that involved kickbacks and where the positive outcomes of the trials were already written before the trials were begun![486] In 2009, the "me-again" drug cost 19 times as much for a daily dose as the original drug. If all patients had received citalopram instead of escitalopram or other SSRIs, Danish taxpayers could have saved around €30 million a year, or 87% of the total amount spent on SSRIs.

The Cochrane review of escitalopram, which has Cipriani as first author, is also disgraceful. It claims that escitalopram is significantly more effective than citalopram.[487] Cochrane also rewards the companies that cheat the most.

Vortioxetine seems to be an exceptionally poor drug. Every author of the trials had commercial ties to Lundbeck, but independent researchers found that duloxetine and venlafaxine were more effective than vortioxetine.[488]

Cipriani's paper was hyped in the extreme on the homepage of one of the Danish regions, which highlighted Lundbeck's expensive me-again drug, escitalopram.[489] Videbech also starred as one of Lundbeck's useful idiots, saying that Cipriani's meta-analysis was "far more credible" than the Danish meta-analysis published a year earlier. He claimed Cipriani had considered the sources of error the Danish researchers had not been aware of. As so often before, which is clear from the textbook he edited,[490] Videbech was highly manipulative.

First, Cipriani's review was of very poor quality while the Danish review was exemplary. This is odd, because two of the co-authors are researchers with whom I have published guidelines

for good reporting of network meta-analyses,[491] and a third is statistician Julian Higgins, editor of the Cochrane Handbook that describes over 659 pages how do to Cochrane reviews.[492]

Second, contrary to what Videbech said, the Danes *did* find a significant drug effect but noted that "all trials were at high risk of bias and the clinical significance seems questionable."

Third, there were no errors in the Danish review, and Videbech and Cipriani had not noted any. Cipriani did not cite the Danish review although it was published 12 months before his own.

Fourth, Cipriani's review was *far less* credible than the Danish review, which only included comparisons with placebo. Head-to-head comparisons of drugs are notoriously unreliable,[493] e.g. significantly more patients improved on fluoxetine when fluoxetine was the drug of interest than in trials where fluoxetine was the comparator drug.[494] Oddly, as Cipriani co-authored also this review, he *knew* that what he published in *The Lancet* was untrustworthy.

Fifth, the effect size in the Danish review was about the same as in Cipriani's review, 0.26 versus 0.30.

The absurdity of it all can be seen by comparing two articles in *The Guardian*. Prozac did not work in 2008 (effect size 0.32),[495] but ten years later, *all* drugs worked (effect size 0.30).

The Guardian 26th Feb 2008

Prozac, used by 40m people, does not work say scientists

Analysis of unseen trials and other data concludes it is no better than placebo

Full text: the PLoS paper



A single Prozac capsule. Photograph: Alamy

Prozac, the bestselling antidepressant taken by 40 million people worldwide, does not work and nor do similar drugs in the same class, according to a major review released today.

The Guardian 21st Feb 2018

The drugs do work: antidepressants are effective, study shows

Doctors hope study will put to rest doubts about the medicine, and help to address global under-treatment of depression

It's official: antidepressants are not snake oil or a conspiracy



It is likely that in the UK alone 1 million more people a year should have access to either drugs or psychotherapy for depression, say experts. Photograph: Darron Cummings/AP

Antidepressants work - some more effectively than others - in treating depression, according to authors of a groundbreaking study which doctors hope will finally put to rest doubts about the controversial medicine.

This affair is emblematic for psychiatry. Virtually all Cochrane reviews and another network meta-analysis by Cipriani, of depression drugs in children and adolescents,[496] should also be distrusted. The clinical study reports the drug companies have submitted to drug regulators are far more trustworthy than published trial reports.[497]

Psychiatrist Ole Bjørn Skausig contributed to the absurd follies when he published, *Should we prescribe the best or the cheapest?,* in our medical journal in 2011.[498] He argued that, "Internationally, escitalopram is recognised as clearly the best SSRI ... experience also counts ... meta-analyses are often of little use, even if they are currently in vogue." He advised that one should double or triple the dose; said it is cheaper for society if the patients become cured; and noted that he often used antiepileptics, lithium, and atypical antipsychotics for patients with depression.

It is rare that doctors so clearly admit how dumb they are. Escitalopram is not better than other depression drugs; clinical experience is highly misleading; meta-analyses of randomised trials is the most reliable evidence we have; drugs that don't work, don't work any better if you triple the dose; no drug can cure depression; and depression should be treated with psychotherapy, not with toxic drugs. Skausig denied that the drug companies had hidden suicidal events on their drugs, which they have, to an astounding degree,[499] and he

claimed I misled the public when I said so. He forgot to tell his readers that he is a psychiatrist and had received honoraria from Lundbeck and Novartis.[500]

**Cochrane review of depression pills in children: dangerous garbage**

As I have shown, a 2021 Cochrane review of depression pills in children[501] was dangerous "garbage in, garbage out" that demonstrated that Cochrane is too beholden to industry.[502] The first author, Sarah Hetrick, is editor in the Cochrane group that published the review. She should have known better.

The abstract is full of nonsense. We are told that "The evidence is very uncertain" for suicide-related outcomes for six named drugs. But we have known for 20 years that depression pills as a group increase the suicide risk in children and adolescents.

The Cochrane authors are beholden to Lundbeck because they suggest that escitalopram may reduce the risk of suicide even though the confidence interval is compatible with a doubling of the suicide risk, which is the correct result for all the drugs.

The abstract is full of subjective expressions such as "at least slightly" and "moderate certainty evidence" and some of the main text is also gobbledygook.[503]

It would be a waste of time to read the review's 225 pages. These drugs should not be used in children or adolescents (see below). But the authors' conclusions are totally absurd:

"Our findings reflect the average effects of the antidepressants, and given depression is a heterogeneous condition, some individuals may experience a greater response. Guideline developers and others making recommendations might therefore consider whether a recommendation for the use of newer generation antidepressants is warranted for some individuals in some circumstances."

The authors apparently don't know what statistical variation is. We use average effects to draw conclusions, but they presented wishful thinking. Their argument can be used about all ineffective treatments, also bogus treatments like homoeopathy. Some people may experience a greater response than others, right? This is Cochrane at its worst.

**Driving children to suicide with happy pills**

Nothing illustrates the lethal power of drug marketing, corruption and fraud better than the fact that it has been possible to convince doctors to prescribe depression drugs to children even though they don't work for them and double their risk of suicide.

The fraud is grave. The companies have hidden suicides and suicide attempts in their trials or have added them to the placebo arm, although they didn't belong there.[504] And the FDA is complicit. In trials of some drugs, there were more suicides (all ages) than in the whole FDA analysis of all the drugs.[505] Thomas Laughren was responsible for FDA's official 2006 meta-analysis. But he published a paper five years earlier using FDA data where he reported 10 times as many suicides per 10,000 patients randomised to depression pills[506] than in his 2006 analysis. It is amazing that it can be so subjective if someone died or not.

The event rate was shockingly high: 2 out of 100 young people experienced suicidality during a few weeks of treatment.[507] Many children who didn't suffer from any psychiatric disorder have killed themselves because of the unbearable harms of the drugs, which they didn't recognise, as they thought they had gone mad.[508]

The drug companies knew how dangerous their drugs were before they marketed them. Eli Lilly knew that fluoxetine could cause a strange, agitated state of mind with unbearable rage, delusions, and disassociation, or an unstoppable urge to commit suicide or murder.[509]

Suicide, violence, and homicide on depression pills and other psychiatric drugs are strongly associated with akathisia,[510] which is a state of extreme restlessness and inner turmoil. It literally means you can't sit still. You may have the urge to tap your fingers, fidget, jiggle your legs, or endlessly pace up and down. Akathisia need not be visible but can cause inner torment with extreme anxiety. Although akathisia is one of the most dangerous symptoms that exist, psychiatrists often overlook or dismiss it. One textbook called key symptoms of akathisia "agitated depression."[511]

In 2011, Lundbeck's director, Ulf Wiinberg, said on Danish radio that depression drugs reduce suicides in children. The journalist and the invited expert from the drug agency were stunned, and I published a letter about it on a science site.[512] Lundbeck's research director, physician Anders Gersel Pedersen, responded in a highly condescending way:[513]

"We have - with regret - read Peter Gøtzsche's open letter, which unfortunately seems characterised by a limited professional insight into the complicated and extremely important issue of suicide and suicidal behaviour associated with depression in children and adolescents, and a possibly increased suicide risk in relation to treatment of depression with antidepressants ... In our view, any dialogue on this important topic should be evidence-based and not just take the form of superficial polemic on an insufficient basis."

Pedersen's article illustrates how people in drug companies think. For them, science is window dressing. I have explained why the references he quoted are highly misleading.[514]

Pedersen argued that that there is no clear relationship between suicidal behaviour, suicide attempts and suicide. This is false. People who display suicidal behaviour are at much greater risk of suicide than people who don't.

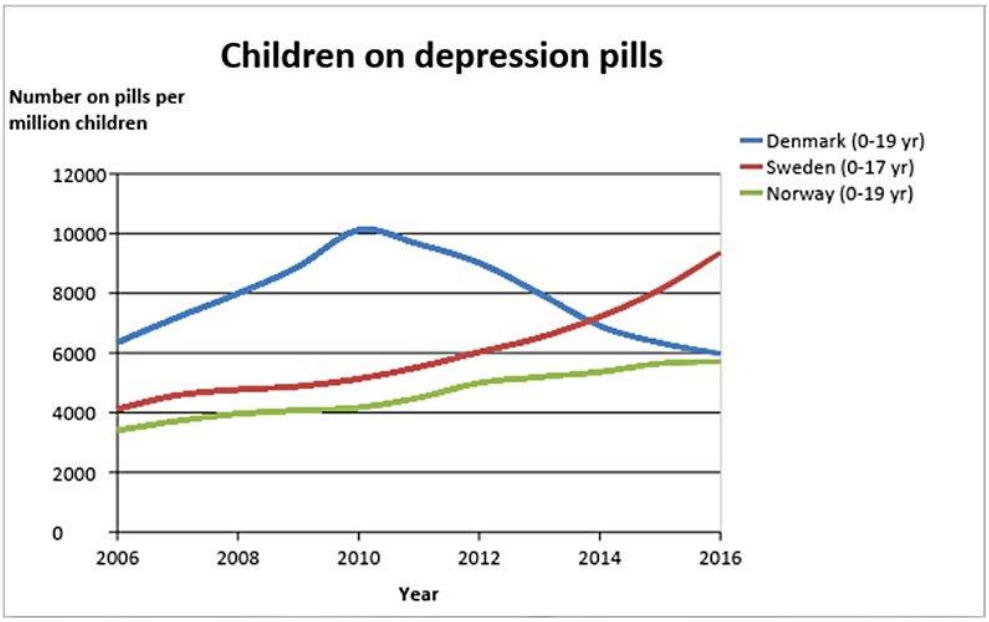
Pedersen quoted a study funded by The Lundbeck Foundation[515] by Kessing who was on Lundbeck payroll. Suicides were 19 times more common when children had been treated with an SSRI. The authors presented another analysis where they had corrected for psychiatric hospital contact. The risk was still increased, 4.5 times, but "no longer quite significant." It is wrong to correct for psychiatric hospital contact, which increases the suicide risk for psychiatric patients 44 times.[516] A correction for a factor in the causal chain will spuriously attenuate or remove a true relationship.

Kessing found that SSRIs dramatically increase the risk of suicide in children but concluded the opposite: "Not treating severely depressed children and adolescents with SSRIs may be inappropriate or even fatal." What is fatal is that we have psychiatric professors like Kessing and Videbech who have cited this study uncritically many times as "evidence" that depression drugs do not cause suicide, e.g. in *Politiken* in 2020.[517] Videbech claimed it is "evident that without clinical experience it is impossible to meaningfully interpret the results of various studies." This is bullshit. I would say that, without a rudimentary knowledge of research methodology, it is impossible to meaningfully interpret clinical research results.

Lundbeck's horrendous lie made me begin to warn strongly against the suicide risk of the pills, in TV, radio, articles, books, and lectures. In 2011, the Board of Health reminded family doctors that they should not write prescriptions for depression pills for children, which was a task for psychiatrists. As they had done this before, to little effect, I am convinced that the huge drop in usage we saw was due to my tenacity (see figure on next page).[518]

Even though psychiatry professors in all three Nordic countries continued to propagate the lie that depression pills protect children against suicide, the number of children in

treatment decreased by 41% in Denmark while it increased by 40% in Norway and 82% in Sweden.




One of the chapters in my book about organised crime in the drug industry is, *Pushing children into suicide with happy pills*.[519] Can anything be worse than this in healthcare? Telling children and their parents that the pills are helpful when they don't work and drive some children to suicide?

In 2013, I debated with Kessing on TV about suicides caused by depression pills. I have uploaded the debate,[520] and bits of it appear in a documentary film.[521] Kessing denied the science and the drug agencies' warnings, saying that we know with great certainty that SSRIs *protect* against suicide. He added that the risk of suicide is large when people stop SSRIs but failed to mention that this is because of the pills' harmful withdrawal effects.

Shortly afterwards, Kessing accused me of being unprofessional and campaigning against antidepressants, claiming that there isn't a single study in the world that has shown that they increase suicides.[522] I replied that Videbech had agreed with me in a debate we had on radio and TV two weeks earlier that SSRIs can cause suicide.[523]

Three days later, I was in another TV debate with Kessing, this time about how we could reduce the consumption of depression pills. Kessing claimed they are not dangerous. Pedersen said it is dangerous *not* to treat the patients and claimed they don't become addicted but get a relapse when they stop taking the pills. Kessing claimed that only 10% of those who visit their family doctor aren't helped - quite a remark about drugs that don't work!

When the interviewer asked Kessing how pill usage could be reduced, he didn't reply. He said we knew for sure that there had been a rising incidence of moderate and severe depression over the past 50 years. This is not correct.[524] I explained that the criteria for diagnosing depression had been substantially lowered during these 50 years, and that the prevalence of severe depression had not increased.

I was constantly harassed by psychiatry professors.[525] Kessing uttered in 2016 that our meta-analyses documenting the suicide risk were unusually unscientific and published in journals of little scientific standing. I see. Using the best available methods and publishing in

journals of high repute, such as the *BMJ*, *Journal of the Royal Society of Medicine*, and *Canadian Medical Association Journal*,[526] apparently equals poor science.

Raben Rosenberg's ravings included "a shrill tone with highly subjective interpretations," "monomaniacal and know-all form that reflects a contempt for the psychiatric profession," "ideological crusade, which is ethically deeply problematic," and "anti-psychiatric campaigns, the background of which is the gross simplification principle."[527]

If you have no arguments, you raise your voice, talk nonsense, or both.

In 2019, two European researchers finally put an end to the lies. They re-analysed FDA trial data and included events occurring during follow-up,[528] which is the right thing to do because, in clinical practice, people also stop taking the drugs at some point. They included all ages and found double as many suicides in the active groups as in the placebo groups.

In our 2016 systematic review in the *BMJ* of the clinical study reports, we found that depression pills double suicidality in children and adolescents and increase aggression 2–3 times.[529] Considering all ages, four deaths were misreported favouring the active drug; 27 of 62 suicide attempts were coded as emotional lability or worsening depression; and the patient narratives listed homicidal threat, homicidal ideation, assault, sexual molestation, a threat to take a gun to school, damage to property, punching household items, aggressive assault, verbally abusive and aggressive threats, and belligerence. Even though akathisia was sometimes miscoded as hyperkinesia, or not coded at all, we found it occurred twice as often on the pills than on placebo.

Our findings are important, considering the many school shootings and other mass murders where the killers were on such drugs.[530] We also know the mechanisms of action. The drugs can cause emotional blunting, psychosis and akathisia.

But the professional stupidity is shocking. When one of the teenage shooters in the Columbine High School massacre was found to have taken a depression pill, the American Psychiatric Association denied a possible causal relation and added that undiagnosed and untreated mental illness exacts a heavy toll on the sufferers.[531] This is sickening industry speak. The other murderer had also taken depression pills.

When we published our review in the *BMJ*, adolescent psychiatrist Bernadka Dubicka accused us of harming young people because we pointed out that depression drugs increase their risk of suicide. He said depression in young people was undertreated; that our paper was fundamentally flawed in presentation and logic; that the *BMJ* misrepresented our results in its press release; and a lot of other dangerous nonsense.[532] Marc Stone from the FDA accused us of having misrepresented an FDA study, which we hadn't, and ironically, he seriously misrepresented not only his own work but also a paper by one of his colleagues.[533] We replied to these unfounded attacks.[534]

Psychiatry professor Lars Mehlum from Oslo said we had defined suicidality very broadly and claimed it was wrong when we concluded that the drugs increase the risk of suicide in children and young people.[535] Other critics were equally unreasonable.[536] Sheraz Yasin found it negligible that we had shown that antidepressants double the rate of activation or other precursor events for aggression and suicidality when given to adult human volunteers compared with placebo.[537] Detlev Degner advised individualised treatments or balanced risk-benefit analysis and called it a "one-dimensional, dangerous ideology" that we suggested prohibiting the use of depression drugs in children and young people. It is evidence-based medicine to call for a ban on using drugs that don't work and increase suicides. And as it is impossible to predict which children will be driven to suicide because of the drugs' harms, individualised treatments cannot be practised safely.

The Science Media Centre in the UK published an “Expert reaction” where five “experts” denigrated our research and pretended it wasn’t a problem that depression drugs drive children to suicide.[538] They claimed that the drugs work in 10-20% of the patients and don’t cause suicide; that the drugs used in the UK were not the same as those we had studied; that the harms may be avoided by close monitoring; and that a doubling in suicides from 1-2 per thousand is a very small increase and less than the suicide risk in people with depression. All of this was false or misleading. The Science Media Centre has a very bad reputation.[539] It promotes corporate views of science and is partially funded by corporations and industry groups whose products the Centre often defend.

Psychiatrists often deny that drugs that perturb brain function can cause violence and homicide. But an analysis of 1,937 cases of violence submitted to the FDA, 387 of which were homicide, showed that violence was particularly often reported for depression pills, sedatives/hypnotics, and ADHD drugs.[540]

In 2018, I described a tragic suicide on depression pills in a newspaper.[541] The parents of Rasmus Burchardt contacted me after their 19-year-old son had hanged himself in their bathroom 18 days after the family physician had prescribed mirtazapine for sleep problems and school fatigue. Neither they nor Rasmus had been warned that depression pills can cause suicide and they wanted me to write about it to warn others.

The pills might have caused psychosis. Rasmus’ girlfriend was worried about a message he had sent the same day: "These fucking pills make the thoughts impossible to stop, and right now I want everything to stop.” She went to the house with a friend and found him dead.

I explained that Rasmus’ story was typical of suicides caused by depression pills. They often come without warning and the method is usually violent, e.g. hanging, shooting, or jumping in front of a train, which almost guarantees that the suicide attempt succeeds. The more common approach is to take an overdose of pills, which is often a cry for help.

My article ignited a lot of discussion. Two leading professors of psychiatry, Poul Videbech and Per Hove Thomsen, and psychiatrist Poul Erik Buchholtz, claimed the pills *protect* against suicide.[542] Buchholtz also claimed that psychotherapy wasn’t an option even though my oldest daughter Pernille and I had shown that psychotherapy for patients who have attempted suicide halves the risk of another suicide attempt.[543]

The chair of the Danish Society for General Medicine, Anders Beich, believed that the long waiting time for psychiatrists could be disastrous, because depression can lead to suicide.[544] It can only be an advantage to have long waiting lists for psychiatrists who prescribe pills that double suicide rates.

In 2018-19, I informed the Boards of Health in the Nordic countries, the UK, Australia, and New Zealand that the consequence of the professional denial was that children and adults continued to die because of pills they thought would prevent suicide.[545] I urged them to act and noted that my warnings had caused the use of depression pills in children to be almost halved in Denmark, whereas it had increased in the other Nordic countries.

I was met with indifference. I got no or late replies, meaningless replies, or outright denial of the evidence.[546] Leaders from the Swedish Board of Health and Drug Agency and four “experts” had written in the Swedish medical journal in 2017 that fluoxetine should sometimes be used in young people: "There is no evidence that treatment with antidepressants increases the risk of suicide. Rather, the evidence points in the opposite direction.” It cannot be worse. Official authorities propagating lethal lies. The Swedish package insert for fluoxe-

tine, which the agency has approved, mentions that suicidal thoughts and suicide attempts, hostility, and mania are common side effects in children. I explained why these drugs should not be used.[547] This time, the Swedish Drug Agency also noted that the pills "do not increase the risk of suicide, and there is some evidence that the risk is decreased."[548]

I wrote to the boards again, attaching a paper I had written about their inaction.[549] The Icelandic Directorate of Health replied that they had asked the psychiatrists in charge of child and adolescent psychiatry to give their opinion nine months earlier, with a reminder, but they did not have time to respond. I replied that this was a tragedy for the children they are supposed to help. I did not get any replies from the UK or Australia. An undated letter from the Ministry of Health of New Zealand said the drug regulator had not approved the use of fluoxetine for children. However, this is no hindrance for usage, which increased by 78% for depression drugs between 2008 and 2016,[550] and a 2017 UNICEF report showed that New Zealand had the highest suicide rate in the world among teenagers.[551]

With Bob Whitaker, I visited John Crawshaw, Chief Psychiatrist and Chief Advisor to the Minister of Health in New Zealand, in February 2018, and I asked him to make it illegal to use these drugs in children to prevent some of the many suicides. He responded that some children were so severely depressed that depression pills should be tried. When I asked what the argument was for driving some of the most depressed children into suicide with pills that didn't work for their depression, Crawshaw became uncomfortable, and the meeting ended soon after.

Lundbeck has been very successful in driving children to suicide. In 2023, the FDA lowered the age for which escitalopram (Lexapro) can be used, from 12 to 7 years based on a trial in generalised anxiety disorder,[552] which was marketing dressed up as science.[553] Ten of the 11 authors had a financial conflict of interest, and the manuscript was ghostwritten. The paper concluded that the drug worked and was well tolerated, both of which were wrong.

Adverse events occurred in 55% of children on drug and in 38% on placebo (P = 0.004, my calculation; there were no P-values for harms in the article), and more children had suicidal ideation (13 versus 2, P = 0.006), "with the most common ideation in the least severe category" (''wish to be dead''; 9 versus 1, P = 0.02). Readers might wonder how, "I wish to be dead" can be the least severe suicidal ideation category.

After the 8-week trial period, 43 children on the drug were switched to placebo cold turkey. This was unethical and violated international guidelines. It is not surprising that it caused some children to experience suicidal ideation or behaviour or that they wished to be dead (according to the supplementary material).

The effect was minor and statistically significant only for one of the three observer rating scales used. The children were not asked how they felt. They would likely have found the drug ineffective, which they did in the two fluoxetine trials in depression we reviewed.[554]

FDA's package insert for Lexapro mentions that, for all antidepressants, 14 additional children per 1000 will experience suicidal thoughts and behaviours on drug compared to placebo. This is an unacceptable harm for drugs that don't work. There are no data on the statistically significant increase in suicide risk in Lundbeck's trial, even though the package insert gives other data from this study, but only for efficacy and only for the scale where the outcome was statistically significant.

The corruption at the FDA is extensive, and I have described it in detail in two of my books.[555] The failure in drug regulation causes some children to kill themselves, which makes

the FDA complicit in this crime against humanity. The only decent action is to ban the use of depression drugs in children.

**Fraud in the two pivotal trials of fluoxetine in children with depression**

Fluoxetine (Prozac) from Eli Lilly was the first SSRI approved for depression in children and adolescents. I decided to scrutinise the two placebo-controlled trials that led to its approval and involved psychiatrist David Healy in this work who adjudicated the adverse events.[556]

I examined the 3,557 pages of clinical study reports Eli Lilly had submitted to the drug regulators and we concluded that fluoxetine is unsafe and ineffective. Essential information was missing; there were unexplained numerical inconsistencies; new outcomes appeared that were not prespecified in the trial protocol (the Texas sharpshooter fraud, see page 226); rating scales and analyses were changed; and the trial protocols were violated in other ways.

The efficacy outcomes were biased by differential dropouts and missing data, but even so, the effect was only 4% of the baseline score, which is not clinically relevant, and patient ratings did not find fluoxetine effective at all.

Suicidal events were missing in the study reports and two suicide attempts were omitted from the journal publication. Precursors to suicidality or violence occurred more often on fluoxetine than on placebo, and for the biggest trial, the number needed to harm was only 6 for nervous system events (a category Eli Lilly used) and 10 for severe harm. Even though the trials only ran for some weeks, fluoxetine reduced height and weight by 1.0 cm and 1.1 kg, respectively, and it prolonged the QT interval on the ECG, which increases the risk of sudden death. Many children developed symptoms compatible with akathisia.

A subsequent publication by Lilly staff had other numbers of suicidal events than those in Lilly's study reports,[557] and a 2007 Lilly meta-analysis of violent events in its trials reported that *fewer* children and adolescents displayed aggression or hostility-related events on fluoxetine (2.1%) than on placebo (3.1%),[558] the opposite of what is correct.

Lilly's rosy results were contradicted by our findings and the FDA, which included a trial of obsessive-compulsive disorder and found 14 vs 3 discontinuations (P = 0.02, my calculation) for reasons related to suicide and violence, and that 6 versus zero children developed mania or hypomania (P = 0.03).[559] A systematic review of all drugs showed that 8% of the children treated with pills developed mania or hypomania versus only 0.2% on placebo.[560] A systematic review including all ages also found an 8% rate.[561]

Fluoxetine is a horrible drug that should never have been approved for anyone. But Lilly was in financial trouble and turned their drug, which they had wanted to shelve, into a blockbuster. Lilly's frauds are spectacular, but other drug companies also indulged in fraud and organised crime and the drug regulators were complicit in this.[562]

David had expected a firestorm when we published our review but there was total silence. The only person that has cited it in a medical journal is me.[563] No one took any interest in our shocking revelations. They came too late to change opinions.

The two journals that published the trials are also corrupt. In August 2023, I wrote to the editors and called for retraction of three fraudulent reports of placebo-controlled trials of depression drugs in children and adolescents, which included a study of paroxetine (GSK study 329).[564] Ten people who lost a child or spouse to suicide as a consequence of being prescribed a depression drug for a non-psychiatric condition - issues that all of us can experience - were co-signatories.

All three trial reports seriously underreported the suicide risk and provided false claims that the drugs are effective.

We told the editors of *Journal of the American Academy of Child & Adolescent Psychiatry* and *JAMA Psychiatry* (previously *Archives of General Psychiatry*) that, "By retracting the fraudulent trial reports and explaining why in accompanying editorials, you will provide a much-needed service to the scientific community and the world's citizens, which will reduce the risk of additional meaningless suicides in children and young people. If you don't act, you will not only sully the reputation of your journals. You will also be seen as being complicit in future suicides caused by antidepressants as a direct harm of these drugs."

Anette Flanagin, Executive Managing Editor, Vice President, Editorial Operations, *JAMA* and *JAMA Network*, replied that she had shared our letter with the author and that "he does not identify any new concerns. Similarly, we do not find new evidence in support of your request to retract this article."[565]

So, *JAMA* and Graham Emslie, who did not mention two suicide attempts on fluoxetine in his trial report and who made numerous other errors, think this is nothing to bother about. Flanagin asked the person responsible for the fraud about his views and accepted them. We would not recommend this method for the police when they investigate a murder. Just ask the suspect if he did it, believe what he says, and ignore all evidence to the contrary.

We asked Flanagin, in the public interest, to reconsider her decision, and, if she still didn't want to retract the paper, to publish an erratum. We also asked her to send Emslie's reply to us and give us the opportunity to publish an account of the many errors he made, asking him to respond in the same issue. Flanagin did not respond. And when I contacted Elsevier, the journal's owner, they did nothing but directed me back to the journal.

Douglas K. Novins, editor, *Journal of the American Academy of Child & Adolescent Psychiatry*, replied that after they had thoroughly reviewed our critique and the responses provided by the papers' authors, they would not do anything. I sent a similar message to Novins as my appeal to Flanagin, but he did not reply.

I have often wondered why it is fruitless to appeal to psychiatrists' inner moral compass. I guess many don't have one and that this is why they became psychiatrists, as they will not be held to account in this specialty.

There is an independent trial of fluoxetine in adolescents, the NIMH's Treatment of Adolescent Depression Study (TADS), published in 2004.[566] This trial was very large and influential. The authors claimed efficacy and safety for fluoxetine, but both claims are wrong. The effect was not clinically relevant, and there were twice as many suicidal events on fluoxetine than on placebo.[567]

Despite over 30 publications, the harms remain misreported. Two researchers got access to summary data via the NIH, which showed 12 versus 2 suicide attempts.[568] When they tried to get access to the case record forms and narratives for serious adverse events, Duke University, where the trial data were lodged, refused to deliver the data even though they had signed an agreement about this.

The researchers also tried to get the missing data from Lilly, which had received all the serious adverse events reports from the investigators, but Lilly refused to release the data.

A psychiatric textbook claimed that fluoxetine is the only drug with a significant effect in children and adolescents and the best tolerated.[569] It is impossible that a drug can be more effective and better tolerated than similar drugs in the same class.

Another textbook acknowledged that fluoxetine increases the risk of suicide in children but recommended to increase the dose in suicidal children! This is like saying that if driving 100 km per hour increases your risk of dying, it will be safer to drive 200 km per hour.

It is not surprising that critical psychiatrists have a hard time in this insane system. I have given numerous examples of fraud and misinformation that drive children and adults to suicide.[570] Medical journals, leading psychiatrists, universities, professional organisations, patient organisations, and the FDA don't care that their activities make them complicit in suicides among children and in harming them in numerous other ways.

It is threatening to the psychiatric guild that depression pills, the most used drugs in psychiatry, increase suicides and violence, and the textbooks are so untrustworthy that some of them even claim that depression pills *prevent* suicides.[571]

**Experts in suicide prevention contribute to the crime against humanity**

So-called suicide prevention experts recommend depression pills and cherry-pick the studies they quote even when they call their reviews systematic.[572]

In 2017, Heidi Hjelmeland et al. documented that it is a myth that mental disorders play a significant role in at least 90% of suicides.[573] In most cases, there is no pre-existing mental disorder. Their article was very difficult to publish. Hostile reviewers accused them of being polemical, climate change deniers, extreme, unbalanced, not trained as psychiatrists, or just expressing opinions. When the article was published and the editor invited comments, none arrived. This is also typical. If you can't win, you keep quiet.

The same year, 29 suicide prevention experts from 17 countries published a consensus report,[574] which quoted a "systematic review" conducted by 18 experts. However, the review did not include the numerous studies or reviews that contradicted the authors' recommendation of drugs as prevention. It was exceedingly difficult for Hjelmeland et al. to publish a criticism of the report.[575] Their paper was rejected by six journals, for political reasons.

In 2020, Hjelmeland et al. published an article online with interviews of professionals about their experiences of implementing the Norwegian guidelines for suicide prevention.[576] The professionals were highly critical of the monopolisation of "the truth" within the suicide prevention community.

One month later, the researchers received a letter from the editors stating they had received a complaint about defamatory content, likely from the National Centre for Suicide Research and Prevention. They wanted to republish the article but would give the researchers the opportunity to withdraw it first. I have also been exposed to this trap. You should NEVER accept such an "offer" from editors who will undoubtedly use the opportunity to reject your paper after additional peer review.

The authors declined the "offer," which resulted in a five-month battle where they needed legal assistance. Nothing was defamatory.

Next, the editors wanted to investigate if there was any basis in the data for the "strong allegations" and demanded that the interview transcripts be handed over. This would have been a serious breach of confidentiality. Instead, the researchers sent material to the editors showing that the national suicide centre had publicly confirmed their findings.

Then, the editors asked the university to investigate the researchers for scientific misconduct. The university gave in to this silly demand and its investigation fully supported the researchers. Only then did the editors accept that the article would remain in the journal.

I corresponded with Hjelmeland about this deplorable editorial misconduct and searched on the Internet to find out what the "experts" opine today. A systematic review from 2021 in the psychiatrists' flag-ship journal, *American Journal of Psychiatry*, was about "evidence-based strategies."[577] The abstract was blatantly false. It claimed that "Meta-analyses find that antidepressants prevent suicide attempts." They have found the opposite.[578]

A 19-page 2015 "State of the Art review" in the *BMJ* claimed that depression drugs, lithium, anti-epileptics, clozapine, ketamine and electroshock can decrease the risk of suicide.[579] None of the 159 references were convincing,[580] and the package inserts for antiepileptics state that they double the risk of suicide![581] In 2017, suicide experts wrote in the Swedish medical journal that antidepressants, lithium, and clozapine prevent suicides, but – as in the *BMJ* paper - several of their references were seriously misleading, and I noted that there is no reliable evidence that *any* drug can prevent suicide.[582]

A 2022 *Lancet* suicide seminar was yet another proof that psychiatry has degenerated to the point of no return.[583] It was very long, 14 pages, but is one of the worst articles about suicide I have ever seen.[584] The authors tried to resurrect the myth about a chemical imbalance in the brain being the cause of psychiatric disorders,[585] but the two articles they cited were gobbledygook. Among risk factors for suicide, the authors mentioned substance use but not depression pills, antiepileptics, or the psychiatric profession itself.[586]

It is also dishonest to say that there is a *possibility* of exacerbating suicidal thoughts, particularly in young people. We *know* that depression pills double suicide rates, but none of the 142 references were to any of the many meta-analyses showing that depression pills increase the suicide risk compared to placebo. Instead, the authors quoted a book written by one of them and by Robert D Goldney who has published a seriously flawed review.[587] He cherry-picked observational studies that supported his idea that depression pills protect against suicide including studies conducted in the Nordic countries that are scientifically dishonest.[588] Goldney had received "gold" "from a number of pharmaceutical companies." No surprise there.

The authors claimed, with no references, that drug treatment can reduce the suicide risk. Which miraculous drugs that can do this? They only exist in the delusional world of the psychiatrists. A little later, the authors spoke about observational studies suggesting that antidepressants might reduce the risk of suicide. This is the UFO trick: If you use a fuzzy photo to "prove" you have seen a UFO when a photo taken with a strong lens has clearly shown that the object is an airplane,[589] you are a cheat. They claimed that randomised trials were underpowered, which is not true if we combine them in meta-analyses.

Unfortunately, one of the most important studies I have come across in my whole career is virtually unknown. In observational studies, people have chosen themselves what to do, e.g. to exercise or not. When comparing two groups, it is common to adjust for baseline differences with statistical methods because they differ in many other respects than exercising or not. However, statistician Jon Deeks showed that it is not possible to adjust reliably for baseline differences. He used raw data from two randomised multi-centre trials as the basis for observational studies that could have been carried out and found that the more baseline variables we include in a logistic regression, the further we are likely to get from the truth.[590] He also found that comparisons may sometimes be *more* biased when the groups appear comparable than when they do not. He warned that no empirical studies had ever shown that adjustment, on average, reduces bias.

Many false claims in psychiatry are derived from observational studies, which is why it is important to know about Deek's research.

The *Lancet* authors claimed that the evidence base is incomplete, since many trials excluded people at high risk of suicide and they noted that *some* research has found an *association* with increased risk of suicide-related outcomes in young people. This is dishonest. When the FDA looked at *all* the randomised trials, they found a *causal* relation and not just an *association*.

*The Lancet* is the extended marketing arm of the pharmaceutical industry,[591] just like the *New England Journal of Medicine*, which has also published articles denying that depression pills cause suicide.[592]

In 2023, the "experts" failed us badly again. In a 16-page article in *BMJ* about suicide in young people, with 169 references, Hughes et al. mention some risk factors, e.g. living in a home with firearms,[593] but not depression drugs, which they recommend with "increased monitoring by the prescribing physician." This is a fake fix, as people may kill themselves suddenly and unexpectedly.[594]

Hughes et al. believe a risk difference of 0.7% for suicidal ideation or suicide attempt between drug and placebo is small, and they dismiss it by saying that "Data from more recent pediatric antidepressant trials have not shown differences between drug and placebo." The review they quote cannot be used to such effect. And when studying rare events, it is unacceptable to lose statistical power by including only "recent" trials. Moreover, the review only included published trial reports, which have omitted many suicide attempts and suicides.[595] It is irresponsible of the *BMJ* to publish such dangerous nonsense.

In 2023, I did a Google search on *suicide and antidepressants*, which confirmed that the public is being massively and systematically misinformed. I documented this in the article, *The lie that antidepressants protect against suicide is deadly*,[596] which I updated a year later.[597] Among the top 10 posts was one from the Danish Centre for Suicide Research that reported that depression drugs increase the risk of repeated suicide attempts by 50%.[598] The research was supported by Lundbeck, and after the researchers had adjusted their analyses for many factors including psychiatric contact and use of various psychiatric drugs, they concluded that the pills do not increase the risk of suicide. As noted above, it is wrong to adjust for something that is part of the causal chain, but they surely pleased their funder.

Another top 10 post was psychiatrist Marianne Breds Geoffroy 's article in our medical journal:[599] *Youth suicide and antidepressants: Peter Gøtzsche claims that antidepressants have driven young people to suicide. But how can he know that?* Well, when a drug increases the risk of suicide, some will succeed. Geoffroy begins her article this way: "Peter Gøtzsche writes that it is antidepressants that have 'driven young people to suicide.' If that is correct, then why are not all children and young people who have depression and are given antidepressants driven to suicide?" Geoffroy 's logical sense seems to be nonexisting. Some people die in traffic accidents, but they don't all die. Geoffroy had received fees from Lundbeck, Eli Lilly and Novartis.

When my first psychiatry book came out, Geoffroy published the article, *Which office stops professors gone astray?*[600] She attempted to get me fired by addressing the Minister of Health claiming I used public funds (which wasn't true) to publish private, non-scientific books, which she compared to Scientology books.[601] I complained about her libellous misinformation. A tribunal concluded she had violated the ethical guidelines and the collegiate

guidelines from the Danish Medical Association and had used language that was totally beyond the borders of a decent debate about healthcare issues.[602]

A month later, in the article, *No one above Gøtzsche*, she once again called my governmental funding into question.[603] She called it bizarre "to extrapolate from the few unfortunate cases to the many … That's how bad things can go when a statistician leaves the desk and strays into real life." She called my book about organised crime in the drug industry, "The first dark book." What is dark is the crimes!

A year later, Geoffroy was on the warpath again.[604] She claimed it was an ideology and a conflict of interest that we had suggested we should demedicalise the population because psychiatric drugs are the third leading cause of death.[605] I thought all doctors were interested in helping their patients to survive. She complained about me to my management, my boss at the university, the Board of Health, the Minister, the committee at the university that handles alleged cases of scientific misconduct, but spared the royal family and our Prime Minister. I noted that anyone can report their neighbour to the police, but sometimes it is the complainant who is the problem, and not the one complained about.

A third post was an announcement in our medical journal of psychiatrist Lars Søndergård's PhD thesis.[606] It was based on Danish registries and found that antidepressants reduced the risk of suicide. The UFO trick is popular in psychiatry.

A fourth post was a comment I made in 2015 on the Board of Health's website.[607] Videbech had claimed in the Board's journal, *Rational Pharmacotherapy*, that undertreatment with depression drugs is dangerous because of the suicide risk. I noted that this cannot be correct because the drugs increase the risk of suicide, and I pointed out other errors.

I don't know of any other medical specialty whose practitioners systematically lie to the public in matters of life and death. Several psychiatrists have told me that their leaders suffer from cognitive dissonance, as what they see and hear doesn't influence them.

In April 2024, award-winning British documentary filmmaker Katinka Blackford Newman launched a petition, *Get suicide prevention services to ask callers if they are taking meds that cause suicide*, to the *Samaritans*, a suicide prevention service.[608] It got over 25,000 signatures in just two months.[609] Experts she had talked to had suggested that medical professionals and helpline staff should ask people with suicidal thoughts if they had become suicidal since going on, changing dose, or coming off a drug that lists suicidal thoughts as a potential side-effect.[610]

The *Samaritans* replied that their volunteers were not medically trained and did not offer advice on prescription medication, which the patients should get from their doctor. In David Healy's view, this should not prevent them from raising the possibility with callers that their problems may be caused by medication. Why is it taboo that depression drugs cause suicide and homicide? This taboo kills people. Katinka is herself a victim of horrible medical malpractice. While going through a divorce in 2012, she was prescribed escitalopram (Cipralex or Lexapro, from Lundbeck) even though she was not depressed, only distressed.

Katinka invited me to the launch of her book, *The pill that steals lives*.[611] She told the audience that she was very lucky to be alive, and not serving a life sentence if she had killed her two children after the pills made her psychotic.[612] She has made a very moving 8-minute film[613] about her story and has a homepage,[614] with links to documentaries and with stories about people who killed themselves or others or were seriously harmed in other ways.

Katinka ended up in the private Florence Nightingale psychiatric hospital in London. The psychiatrists didn't realise it was the pill that had made her ill. They diagnosed psychotic

depression and forced her to stay and take a dangerous cocktail of drugs. But her 11-year-old son Oscar knew it was the pills. What saved her was that her private insurance ran out.

As an introduction to her book, I wrote: "This book describes in vivid detail how ordinary people can become murderers if they take antidepressant drugs and how psychiatry can destroy people. It is a catching personal testimony about what is wrong with psychiatry, its love affair with unscientific diagnoses and harmful drugs, and its blindness towards the fact that what look like psychiatric diseases are often side effects of psychiatric drugs."

Psychiatrists who continue to deny the facts often say that if depression drugs increase suicides, it should be easy to see this if we compare suicide rates with drug usage. Actually, many studies have shown this, but the research literature is flawed and some studies are even fraudulent. The best studies are those that follow what happens after suicide prevention programmes are implemented. They show that suicides increase![615]

**Double homicide in Holland caused by a depression pill**

Many people who have committed homicide while taking depression pills were normal before starting them, developed akathisia when taking them and returned to their normal personality when they came off the offending drug.[616]

Psychiatrists deliberately ignore this harm. A large study that found that a depression diagnosis is associated with a three times increased risk of violent crime mentioned drug treatment as a possible confounder but dismissed this possibility without investigating it, which is inexcusable.[617] And it is not a confounder; it is the cause of violence.

I was an expert witness in a homicide case in Holland in 2016.[618] Serious professional malpractice played a crucial role when Aurélie Versluis killed her two children. She had clear symptoms of akathisia on paroxetine but her pleas for help were ignored. When she became suicidal, instead of withdrawing the drug, her psychiatrist advised continued use.

Versluis had nightmares where she slit her children's throats, which she ultimately did, and also tried to kill herself. Two days prior to the homicides, she asked her supervisor and several other people for help; she visited her family doctor and her company doctor, but both dismissed her, and she contacted her psychologist who did not have time for her.

It is a gruesome story. She was not herself, which a forensic psychiatrist confirmed three days after the homicides. Her doctors stopped paroxetine cold turkey when she was in the psychiatric penitentiary, causing serious harm that persisted for five months. She got a long jail sentence, but questions were raised in parliament if the judicial system was too harsh. Indeed. She should have been released because of drug-induced insanity.

The expert for the prosecution, Anton Loonen, did not have any arguments against my testimony. In the middle of the proceedings, he handed over a document to the court he had written in Dutch. He suspected I suffered from a mental disorder that made me seriously disinhibited and advised that I should be examined by a doctor to protect myself from myself. This was the third time I had been "diagnosed" by someone with a psychiatric background who did not know me and had not examined me but held some grudge against me.

Loonen contacted the press and called another expert witness, Dr Selma Eikelenboom-Schieveld, a charlatan in a newspaper. She complained to the Regional Disciplinary Court, which reprimanded Loonen and found that he, as a judicial expert, in an improper way had wanted to influence the criminal process. The Public Prosecution Service concluded that Loonen's offense was criminal.

The prosecutor asked for a 14-year jail sentence for Versluis and a hospital order for compulsory treatment. I wrote to Versluis's lawyer that nothing would work for her other than keeping her away from psychiatric drugs.

Loonen realised he was in trouble and sent me a curious letter a month after the proceedings. He alleged misunderstandings and claimed that his defamatory note about me - which he had openly distributed in court - was confidential. He disagreed about akathisia and considered himself an expert on this. He noted that he was anxious to learn why I called psychiatry a pseudoscience and that he would like to invite me to dinner to discuss the background of my "ideas and feelings." The letter opened with "Dear Peter" and ended with "warmest regards." But the atmosphere between us was ice cold. He provided unjustifiable support for the prosecution, which is unforgivable.

Four months after the proceedings, I lectured about psychiatry at a meeting in Leiden.[619] Loonen had tried to prevent me from speaking. He wrote to the organiser claiming that I had violated the requirement of confidentiality as an expert witness by making public his reports to the court. This was not true. I had shown his defamatory note to a journalist, which I was entitled to do as there was nothing confidential about it, and as I needed someone to translate it for me during a break in the proceedings. Interestingly, another speaker in Leiden, Allen Frances - once regarded as the most powerful psychiatrist in the United States - said during his talk that I had provided a tremendous service to psychiatry.

Versluis was sentenced to 9 years in prison followed by preventive custody. The case was appealed to the Supreme Court and Versluis's lawyer wanted me to participate. The court refused, arguing that I couldn't provide unbiased research because I had already presented my views. Where is the logic in this? Even if you do your best to be unbiased, the mere act of participating disqualifies you!

Later, I complained over Loonen's unethical conduct to the institutions where he worked and to the Dutch Medical Association, which turned me down with the excuse that I was not a Dutch doctor. In every instance, I was told it was none of their business, or that I should complain elsewhere. The University of Groningen ignored me for two years, and it took six emails before they reacted. The Dean told Loonen that his conduct was inappropriate and that he must prevent the university from suffering possible damage because of his behaviour.

I also lodged a complaint with the Regional Disciplinary Tribunal in Groningen, which dismissed my complaint. This upset one of my Dutch friends, Dr Dick Bijl, so much that he involved a lawyer who filed a complaint against Loonen at the Central Disciplinary Tribunal on my behalf in January 2018. The verdict came 19 months later. Loonen's statements about me were considered inappropriate and his "diagnosis" was unsubstantiated, which The Regional Disciplinary Tribunal wrongly ignored.

Versluis' case constitutes a serious miscarriage of justice. I succeeded in contacting her in 2024. She is out of prison, has a job and a boyfriend, and is well-functioning. She must be a very strong person.

**How to harm people from birth with a depression pill**

Depression pills should be avoided during pregnancy, as they can cause miscarriages, birth defects, behavioural abnormalities and other serious harms in the newborn.[620] But the textbooks were inconsistent, confusing, and misleading and tended to put the blame on the disease, not on the pills.[621] Two books warned that depression might cause malformations and

neonatal complications, but what they described were drug effects. One book noted that the Board of Health recommended always to consider psychotherapy, but it advised that if the women had been depressed earlier, they should be treated *prophylactically* with depression pills to reduce the risk of relapse from about 70% to about 25%. It is impossible to justify this recommendation, and the miraculous effect doesn't exist.

The WHO has recommended a screening test for depression that is so poor that 36% of healthy people will get a false depression diagnosis.[622] Imagine if we screened healthy people for cancer with a test that gave a third of them an erroneous cancer diagnosis. We wouldn't allow this. Videbech claimed I was wrong when I said that a depression diagnosis was based on a simple test, but he blamed me for his own mistakes. He had recommended exactly this,[623] and many patients reported that there was no further testing.[624]

Curiously, after a Cochrane review had recommended against screening,[625] the Danish Board of Health advised screening for a huge number of poorly defined "risk groups."[626] When I pointed out at a scientific meeting that this would lead to treatment of many healthy people with depression drugs, Kessing replied that it didn't matter that we treated healthy people because SSRIs have no side effects![627] He also said: "Screening cannot do harm."

The Board of Health had gone totally mad, too.[628] They acknowledged that SSRIs increase the occurrence of spontaneous abortions, decrease birth weight, likely increase the occurrence of birth defects, increase the risk by a factor of five for developing pulmonary hypertension (a lethal harm estimated to occur in 6-12 newborns per 1,000), and increase neonatal complications such as irritability, tremor, hypertonia and difficulty sleeping or breast feeding - the neonatal abstinence syndrome.[629] They nonetheless recommended routine screening of pregnant women and subsequent pill treatment.

A Danish cohort study showed that SSRIs double the risk of heart septum defects,[630] which means that 1% of the treated foetuses will get it. This was expected because serotonin plays a major role in the functioning of the heart. Some people who took diet pills that increase serotonin, developed deadly valvular defects and pulmonary hypertension, and these drugs have been withdrawn from the market.[631]

The Board's recommendation of screening pregnant women is so absurdly harmful that I wrote a sketch about it.[632] Psychologist Olga Runciman and I spontaneously performed it as the introduction to my lecture about psychiatry at a meeting in 2013 by reading it aloud from my computer. I have uploaded it, with English subtitles.[633]

A textbook claimed that the risks of depression and behavioural disorders are increased in 18-year-old children of mothers who are not treated during pregnancy for their depression. As this cannot be true for drugs that don't work, I looked up the cited evidence. It was a clinical guideline about psychiatric drugs and pregnancy produced by the Danish Psychiatric Association, the Danish Society for Obstetrics and Gynaecology, the Danish Paediatric Society, and the Danish Society for Clinical Pharmacology.[634] With so many knowledgeable people involved, one would expect the guideline to be useful, but it was dishonest.

It cited two studies. One showed that if a woman is depressed, the risk of her offspring becoming depressed is increased, but only for mothers with low education.[635] This subgroup result has nothing to do with depression treatment but reflects depressing living conditions.

The other article didn't find that untreated depression in the mother increases the risk of behavioural disorders in the child,[636] but the study authors didn't like their result and went fishing in the data till they found an old boot which they presented as if it were a fish!

Earlier, information about drugs was provided in a small handbook published by the Danish Medical Association, which all doctors carried with them. It was of high quality and

often recommended cheap drugs that were out of patent. We all loved "the little green one" while the drug industry hated it. In 2003, the industry succeeded in removing it, and from then on, the industry foxes were guarding the hen house. They published "the big green one," which was a huge setback for public health. This book was later replaced by a website, medicin.dk, which is also under industry influence and whose secretariat is located in the same place as the Danish Association of the Pharmaceutical Industry.

The industry entanglement is a huge problem. Several cases of infant deaths and birth defects could possibly have been avoided if medicin.dk had updated their text on harms. Several research results from 2005 to 2010 showed an association between the use of depression pills and birth defects, but up to April 2011, the editors recommended use of the drugs in pregnant women. In 2010 and 2011, the Danish Medicines Agency warned several times about the danger of deformities, without medicin.dk changing the text. A journalist revealed that the editor, physician Court Pedersen, had shares in Lundbeck.[637]

**Denial and abuse of power in Australia**

In February 2014, Bill Thomson, an Australian farmer whose only son James took his life at age 19 while on venlafaxine, wrote to me that he wanted to inform people about how dangerous depression drugs are. He had read over 20 books on Big Pharma malpractice and said that my book about organised crime[638] "shone the strongest light on the issues."

Bill wanted so much that I go on a lecture tour that he visited me in Denmark to ensure I wouldn't back out. He was a superb organiser and spent a whole year on arranging the tour. In February 2015, I gave 17 lectures on different subjects in just 11 days at public venues, hospitals, and universities, and I was interviewed for radio, TV, and newspapers in what was described by the Australasian Cochrane Centre as a whirlwind visit to Australia.[639] Bill sent me a list afterwards showing that my visit had been covered by 85 different media.

Shortly before I came, two Australian child and adolescent psychiatrists, Jon Jureidini and Peter Parry, and I published the article, *Dreams of a quick fix, gone awry*, about the tour where we noted what was wrong with psychiatry.[640]

I found the power structure in Australian psychiatry very disturbing and heard many stories about how the higher-ups had prevented an open debate about issues of crucial importance. Two psychiatric professors stood out: Ian Hickie and Patrick McGorry, both of whom had numerous conflicts of interest in relation to the drug industry.

Hickie led a clinical trial, which investigated if sertraline could prevent depression in people who were not depressed. There were major problems with the trial. For example, sertraline was abruptly stopped, which was justified as being common practice!

McGorry spearheaded equally absurd trials about using antipsychotics to prevent people who had never been psychotic from developing psychosis. He published one such trial,[641] while another trial, of quetiapine in children as young as 15 was halted after international protests.[642]

In 2014, Maryanne Demasi from the *Australian Broadcasting Corporation* (*ABC*) worked on a documentary about antidepressants and interviewed David Healy and me. We used a lot of time refuting Hickie's arguments and explaining to Maryanne why he was wrong.

Hickie teamed up with McGorry and their power was so great that when they refused to appear on camera, *ABC's* leadership cancelled the documentary. This is not a valid reason for dropping a highly relevant programme. Journalists can just say they refused to comment.

Demasi had worked hard to get the facts right, and I saw many of Hickie's denials, which were extraordinary. He denied that depression drugs increase the suicide risk in children and referred to Robert Gibbons' work, which is scientifically dishonest;[643] he claimed that FDA's Black Box Warning about the suicide risk wasn't justified and might have caused harm; he said suicidal thoughts are not the same as completed suicides; he claimed that depression drugs do not cause a chemical imbalance; he rejected the fact that general practitioners don't have time for full mental health histories and follow ups (a US study showed that over half the physicians wrote prescriptions after discussing depression with patients for three minutes or less[644]); he claimed that an extensive literature showed that the drugs can prevent relapse; and he opined that the reason there was no wide debate about psychiatry was that the critique came from fringe groups. Quite a mouthful of false statements.

Hickie keeps Australians in the dark but some of my talks were filmed and are available, e.g. *Mental health: overdiagnosed and overmedicated*.[645]

By refusing to appear on TV, Hickie got off the hook in another matter. He knew that Maryanne would ask him about his conflicts of interest in relation to a review he published in *The Lancet*.[646] It was about melatonin-based depression drugs, but "In particular, we highlight agomelatine," which got four pages, whereas four other drugs only got one page in total. Both authors had numerous ties to Servier that sells agomelatine. They claimed that fewer patients relapsed on agomelatine (24%) than on placebo (50%), but a systematic review by other psychiatrists found no effect on relapse prevention, no effect on symptoms, and none of the negative trials had been published.[647] Three pages of letters – which is extraordinary – in *Lancet* pointed out the many flaws in Hickie's review.

I described these issues in my first psychiatry book and they were also mentioned in the article, *Cochrane co-founder savages Aussie psychiatrists*.[648] Dermatologist Samuel Zagarella, had arranged a talk for me and he said it's impossible to learn the facts by going to lectures run by conflicted psychiatrists and drug companies and that every medical student and practicing doctor should read my two books about deadly medicines and deadly psychiatry.

In 2024, Hickie said to *ABC* that when the usage of antidepressants goes up, suicides and suicide attempts go down; that depression is a biological disease that leads to social problems, not the other way around; and that depression drugs and ECT are "wonderful treatments."[649]

Australian psychiatrist Niall McLaren told me that his specialty has all the trappings of a money-making cult based on ideology rather than science. This is also how people describe Scientology. It is taboo for the media to challenge the cult's beliefs. A reporter who did this said she would never do it again and was threatened with dismissal. Why? Because drug companies and medical lobbies immediately get on the phone to the Minister of Health and complain loudly saying it will harm patients to suggest that the drugs may harm them. This is one of the many signs that psychiatry is a mad cult (see page 208).

Ordinary Australians are smarter than Hickie. In a large survey, people thought that antidepressants, antipsychotics, electroshocks, and admission to a psychiatric ward were more often harmful than beneficial.[650] This agrees with the science, but the social psychiatrists who did the survey were dissatisfied with the answers and argued that people should be trained to arrive at the "right opinion." How? More brainwashing by psychiatrists like Hickie?

When the "customers" don't agree with the salespeople, the providers are quick to change their products or services. This doesn't happen in psychiatry with its monopoly on treating patients with mental health issues, which have family doctors as the complacent frontline sales staff who don't ask uncomfortable questions about what they are selling.

## Anxiety: not a pill issue

In my first psychiatry book,[651] I describe eight tragic suicides caused by depression pills the relatives wanted me to write about to warn others. None of the patients were depressed. They all suffered from anxiety. In one of the cases, the general practitioner added false information to the clinical record after the patient had hanged himself. I have heard a lot about this type of crime - obstruction of justice - where doctors change facts that would look bad in a court case.

When I launched the book at a meeting in Copenhagen in 2015, five of the involved women heard about it and came at their own expense to talk about their losses. There was total silence while they recounted their shocking stories, which I have uploaded.[652]

In contrast to drugs, psychotherapy is highly effective.[653] I have explained why anxiety should not be treated with pills, and how misleading the textbooks are. The Board of Health has noted that the effect is not increased by adding pills to psychotherapy,[654] but even though the textbooks often advise psychotherapy they also recommend depression pills, especially if the condition is severe, including for children. People on drugs don't learn how to cope with their anxiety. Taking a drug is like alleviating the tension with alcohol.

In 2014, the chair of the Danish OCD Association, Bettina Broni, argued that the patients should take depression pills and ignore the tragic stories about people who killed themselves while on SSRIs.[655] She claimed that the drugs protect against suicide, also in children, and that to ask a patient with OCD not to take an SSRI was like asking a diabetes patient not to take insulin. Her article might as well have been written by Lundbeck, Videbech or Kessing.

I explained in their members' journal why depression drugs should be avoided,[656] which prompted a former patient to write her story – a typical one.[657] Aged 16, her psychiatrist gave her a pill saying it would stabilise serotonin in the brain. She got suicidal thoughts, but six years later, she was still drugged. Her doctors were only interested in renewing her prescriptions. When she had persuaded her fourth psychiatrist to taper off the drug, the happiness she felt was indescribable. She noticed the beauty and joy of birdsong for the first time in years. She hadn't made any progress before she stopped the pills, helped by her psychologist. Another psychologist, who was against using drugs, told me his name had been deleted from the list of therapists at the OCD Association.

People suffering from anxiety should avoid psychiatrists. Anxiety is often the entry ticket to psychiatry, with subsequent additional diagnoses, polypharmacy, a ruined life, and death for some patients. A doctor I know had an emotional crisis and lost seven years to psychiatry because of serious medical malpractice committed by her psychiatrist. She wrote: "One day, it was like the penny dropped and I laughed out loud when I realised that I had been prescribed medication to treat my psychiatrists' anxieties. They should have been the ones taking my pills."[658]

In 2023, I published the article, *Psychiatry killed Tuva Andersson, whose problem was anxiety*.[659] Her mother contacted me, as there had been no justice. It is a harrowing story. Tuva was a victim of malpractice stemming from professional incompetence and gross medical negligence. She felt stigmatised by a variety of ever-changing, nonspecific diagnoses, and was exposed to forced treatment. This included a depot injection of a neuroleptic it was impossible for her from to escape from. During the last year of Tuva's life, her psychiatrists took away all hope of recovery, which killed her.

Tuva was only 37 years old when she killed herself with two of the drugs she had been prescribed, amitriptyline and zopiclone.[660] A local newspaper, *Hudiksvall Tidning*, stated: "The personal disaster that befell this family involves so many mistakes in the chain of care that it is mind boggling. How is that even possible, one thinks when reading the story of Tuva. Everyone can make a wrong decision at some point. But not all the time."

Unfortunately, in psychiatry, people do make wrong decisions *all the time*.

Two of my friends, Steven Woloshin and Lisa Schwartz (died in 2019) from Dartmouth in the USA showed that if patients are told the facts, they are much better at choosing a good drug or no drug and in knowing what the benefits and harms are.[661]

If people knew that the effect of sleeping pills is to make them fall asleep 15 minutes faster,[662] and to make them dizzy and drowsy the next day, they might be less interested in taking them, and if they also knew that the effect disappears within two weeks if they take them every night, few people would become addicted to them.

Steve and Lisa convinced the FDA's Risk Communication Advisory Committee that the agency should adopt their suggestions. However, after having thought about it for a year, the Department of Health and Human Services announced it needed at least three more years to come to a decision.[663] An initiative that indisputably helps patients to choose rationally between drugs, or even to say no to drugs, seems to be almost an attack on the state. It could lead to loss of income for the drug industry and the many people it corrupts.

It is now 13 years ago that the government needed another three years to think about this excellent initiative, and the FDA stalled. Some call it the Foot Dragging Agency.

## ADHD: a bogus diagnosis and not a pill issue

In terms of overdiagnosis, clinical research, and the harms inflicted on millions of healthy people, Attention Deficit Hyperactivity Disorder (ADHD) is yet another disaster area. Patients and their relatives often refer to ADHD drugs and depression pills as "Psychiatry's Starter Kit." Many people start their psychiatric "career" by consulting their family doctor with some problem many of us have from time to time and get a prescription, which starts a chronic course with multiple diagnoses and drugs, and deterioration.

ADHD was invented in America. Joseph Biederman did a lot to promote the diagnosis and get it included in the DSM manual.[664] In just five years, he received fees from more than 24 drug companies, and Janssen alone gave him over one million dollars.

No one knows what ADHD is,[665] and there is a good reason for that. It doesn't exist as a concrete thing but is just a name for people at one end of a normal behavioural spectrum who are more energetic and irritating than others. Obviously, we cannot all display average behaviour. At one end, we have those who get an ADHD diagnosis. At the other end, we have people who are quieter than average who get an Attention Deficit Disorder (ADD) diagnosis. Maybe we shall also one day see a diagnosis for those in the middle, Activity Normal Disorder (AND), who will then also need drug treatment to become supernormal.

Methylphenidate (Ritalin) is the modern version of the cane. We are no longer allowed to beat noisy children but are allowed to alter their brains with a narcotic on prescription (most ADHD drugs are amphetamine or related substances). We medicalise the inevitable conflicts and difficulties that arise between children and their parents or other adults and blame them on a neurodevelopmental disorder or brain disease although no one has shown that

the brains of people so labelled is different to that of others,[666] which DSM-5-TR explicitly acknowledges.

To postulate that hundreds of millions of people have wrong brains is as outrageous as it gets. It is a flagrant abuse of a faulty disease model.[667] I googled "what causes ADHD" and found this misinformation from the UK National Health Service:[668]

"ADHD tends to run in families and, in most cases, it's thought the genes you inherit from your parents are a significant factor in developing the condition … Research has identified a number of possible differences in the brains of people with ADHD from those without the condition … Other studies have suggested that people with ADHD may have an imbalance in the level of neurotransmitters in the brain." *All of this is plain wrong.*

I have heard many psychiatry professors say that genetic factors are the most important causes of ADHD. Per Hove Thomsen noted that genes can explain 80%,[669] and Kerstin Plessen said that there is 80% agreement for identical twins.[670]

So, people who are identical are pretty much identical also when it comes to behaviour. Surprise, surprise. But if we look for genetic abnormalities, we don't find anything. In one study, which claimed ADHD was related to this, combining two tables shows that 99.7% of the patients don't have genetic abnormalities.[671]

Many children qualify for the diagnosis because they are talented and cannot sit still in poorly disciplined and boring classrooms, or because they have emotional problems generated at home. A family doctor told me that a schoolmistress had sent most of her pupils for examination on suspicion of ADHD. It was clearly she who was the problem, but as soon as the kids are branded with ADHD, it relieves everyone of any responsibility or incentive to redress the mess they have created, whether at school or at home. It also increases inequality. ADHD drugs are prescribed much more if the parents have low-skilled jobs.[672]

A Canadian study of one million school children showed that the prevalence of children in drug treatment in the same class increased linearly over the calendar months,[673] and 50% more of those born in December were on drugs than those born in January. This demonstrates more than anything how fake the diagnosis is. We should allow the children to grow up and mature.

**Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist**

| Patient Name | | Today's Date | | | | | |
|---|---|---|---|---|---|---|---|
| Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment. | | | Never | Rarely | Sometimes | Often | Very Often |
| 1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done? | | | | | | | |
| 2. How often do you have difficulty getting things in order when you have to do a task that requires organization? | | | | | | | |
| 3. How often do you have problems remembering appointments or obligations? | | | | | | | |
| 4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started? | | | | | | | |
| 5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time? | | | | | | | |
| 6. How often do you feel overly active and compelled to do things, like you were driven by a motor? | | | | | | | |
| | | | | | | | Part A |

During my lectures, I have often asked the audience to test themselves with the diagnostic criteria for adult ADHD (see previous page). If you land in the grey area four times, you "have" ADHD. The test is so foolish that 25-50% test positive. I tell people not to worry because some of the most talented and wonderful people I have met are like that. At a dinner in my home, we were just four people: my wife, myself, our youngest daughter Ida, and her very laid-back boyfriend. We came to talk about ADHD and tried the test. We all tested positive.

When I lecture, people sometimes say they have ADHD. I reply they can have a dog or a car but not ADHD, which is just a name. When we give a certain behaviour a name, we cannot say that a person behaves this way *because* he has ADHD. This is circular evidence. Unfortunately, the psychiatrists talk about their social construct, as if it existed in nature and can attack people. For example, the authors of the adult ADHD checklist noted that adult ADHD can have a significant impact on relationships, careers, and safety of the patients suffering from it.[674]

In 2024, a newspaper applauded that more and more middle-aged and older people got diagnosed and noted that they have to "live with ADHD."[675] You can live with a cancer, which really exists, but "living with ADHD" just means living with yourself, which we all do, so this is an empty statement.[676] The article noted that the diagnosis provides an explanation for people, which is impossible, as it is just a name.

In 2004, the New York University School of Medicine Adult ADHD programme offered a free screening day at a hotel and found that 85% of adults tested positive.[677] When only half of them contacted a doctor subsequently, the director of the programme said that "people with ADHD need help to get help." Stupidity has no limits.

The stigmatisation and loss of self-esteem, which often follows a psychiatric diagnosis, is especially ominous in children who have yet to shape their personalities. They may view themselves as disabled, with impaired self-determination and increased feelings of helplessness.[678]

UK child and adolescent psychiatrist Sami Timimi asks parents, who believe that a drug will help their child, what changes they are hoping to see and what their concerns are, e.g. behaviour at home, peer relationships, academic performance at school, or a lack of a sense of danger. He might then say that no drugs can alter these things in their child.

This way, Sami diverts the parents' interest from drugs to developing parental management skills for children who are more "intense" than most. A UK documentary showed children who were very difficult to handle. The families got help from psychologists and learned that the children were disturbed, which was why they were disturbing. A mother who always reprimanded her "impossible" daughter was taught to praise her instead, and she developed into a very nice child that was no longer hostile towards her mother.

The ADHD diagnosis should not be a prerequisite for getting extra help or money for schools, as it increases the prevalence of the diagnosis. But doing the right thing in psychiatry is difficult. A child psychiatrist I know was suspended because he didn't drug the children.

About 10% of children have been sexually abused, and in some cultures, it is way more. About half of the women at psychiatric hospitals have been sexually abused as children, and in most cases, hospital staff are unaware of this.[679]

If a child behaves badly, is provocative and defiant, it can lead to a diagnosis of ADHD or borderline personality disorder, although it might be a reaction to a horrible abuse the child doesn't dare talk about. Not even when the children talk about it, is it always taken serious-

ly. A young woman who told her psychiatrist that she had been sexually abused got the reply that this was beside the point. All that mattered to him was the questionnaires he used for making diagnoses. Many patients have told me it took years before they met a psychiatrist who took an interest in the serious trauma, they had experienced.

The indoctrination of psychiatrists is highly effective. In 2022, one of my friends lectured in critical thinking for psychiatry residents. He asked them to review three studies claiming that kids with an ADHD diagnosis had genetic abnormalities or smaller brains than other kids.[680]

The residents emphasised that the genetic differences were highly significant and said that the brain volume study suggested that ADHD was a neurodevelopmental disease.

My friend was flabbergasted. When he explained that their views were not supported by the studies they had just read, they became hostile. Didn't he understand that ADHD and other psychiatric disorders were biological disorders, like diabetes or cancer?

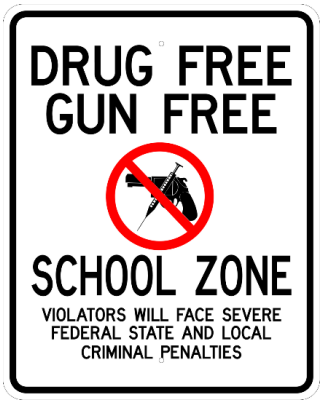
This was the most hopeless insanity in psychiatry he had ever experienced. It is frightening that such people are supposed to take care of psychiatric patients in an evidence-based fashion. They are unable to do this, as it requires a minimum understanding of science.

The study claiming that children with an ADHD diagnosis have small brains[681] has been widely condemned and a re-analysis of the data found no brain differences.[682]

The Americans are always the worst when it comes to psychiatry. The American Academy of Child and Adolescent Psychiatry writes on their homepage that ADHD is a brain disorder and that scientists have shown that some brain structures in children with ADHD can be smaller than in children without ADHD.[683]

In 2011, my wife and I got very angry when an ADHD bus visited Ida's school and distributed brochures to "raise awareness of the ADHD disorder in children." It was all about pushing drugs. The bus was owned by the Danish ADHD Association, which received financial support from companies selling the drugs and producing brochures. The director of the ADHD Association was hired because of her "commercial orientation," with a focus on establishing "partnerships with private companies."[684] Absolutely disgusting this was.

In the USA, you can be met with this warning:




But in American schools, over 10% and are on legal speed.[685] It is a paradox that teachers are more effective drug pushers than those in the streets. Particularly because schoolteachers have observed that exercise makes the children calmer and more attentive, and the effects are huge. Trials have shown an effect size of 0.92 for improved inattention, 0.82 for inhibitory control, and 0.52 for cognitive flexibility.[686]

The short-term benefit of the drugs is that children may sit still in class, but the effect disappears quickly, and the harms include tics, twitches, reduced spontaneous mental and behavioural activity, reduced social interest, apathy, indifference, and depression and compulsive, meaningless behaviours, which animal studies have confirmed.[687]

There seems to be no long-term benefits from ADHD drugs, only harms. The only large, long-term randomised trial, the MTA study, financed by the NIMH, was dishonest.[688] The investigators had excessive financial conflicts of interest and drowned their negative results in complicated statistics that were difficult to interpret, even for me, and the limited relevant data there were showed a *higher* rate of substance abuse in the methylphenidate group than in the behaviour therapy group.[689] There were no differences for school grades, arrests, psychiatric hospitalisations, or other relevant outcomes.

Instead of deliberately obfuscating the disappointing results, it would have been much easier to honestly describe them, but none of the over 100 scientific papers the MTA study generated did that, and the NIMH issued a news release that was a huge lie: *Improvement following ADHD treatment sustained in most children*. The stunting of growth ADHD drugs cause is huge. After 16 years, those who consistently took their pills were 5 cm shorter than those who took very little, and there were many other harms.[690] But rather than saying that the growth of children on drug treatment was stunted, the press release said that children who were not on medication "grew somewhat larger." Based on what we know about other brain active substances,[691] and the fact that ADHD drugs reduce mental activity and interaction with other people, which are important for brain development, it seems likely that ADHD drugs may harm the brain permanently.

One textbook had 19 references but no discussion of the MTA trial that annulled its wishful thinking. It advised to continue with drugs for as long as there is clinical effect, and the harms are tolerated. It is impossible to judge if there is any benefit in the individual case.

Another book claimed that drugs improve social interaction, alleviate aggression, have a moderate to large effect, and reduce the risk of drug abuse. The authors did not discuss the MTA study but provided three references to totally misleading research.[692]

It is popular in psychiatry to blame the victim. A textbook noted that, in *high* doses, the drugs may trigger or aggravate depressive and psychotic symptoms if the patient is *predisposed*. Such symptoms may occur on usual doses and without any predisposition. The author, child and adolescent psychiatrist Søren Dalsgaard, provided two references to his own observational studies, which were not illuminating. One noted that children with ADHD had criminal convictions in adulthood five times more often than the general population.[693] What are we to make out of that? We cannot reduce crimes by using drugs. Dalsgaard did not mention the MTA trial, and his other study was even worse.

He noted that for every year drug treatment was postponed in children, the risk of drug abuse increased by a factor of 1.5.[694] Thus, the risk of drug abuse is 130 times higher ($1.5^{12}$) if a child starts treatment at age 18 rather than at age 6. I calculated from the article that the background rate in the population is 0.69%. Thus, 0.69% x 130 = 90% of all children with an ADHD diagnosis from age 6 will become drug abusers if they are not treated before age 18. I probably extrapolated too liberally, but the study is absurd. There must have been huge confounding. Children who start drug treatment late are very different to other children.

Danish child and adolescent psychiatrist Lisbeth Kortegaard and US psychiatrist Peter Breggin have gradually withdrawn ADHD drugs from every child that came their way and have both experienced that it improves the child's condition given the parents agree and work on improving their parental skills. Lisbeth has stopped psychiatric drugs in many

children and has never seen anyone who deteriorated.[695] I have lectured several times with them, and Peter believes we should prohibit giving psychiatric drugs to children, just like we have prohibited physical and sexual abuse.[696] I agree. Drugging children should be illegal, with very rare exceptions.

Psychiatrists lie profusely about ADHD drugs. At a hearing in Parliament on 27 May 2013 where Lisbeth lectured, Tine Houmann said that methylphenidate protects against crime, delinquency, and substance abuse. Houmann got very angry when she didn't get away with her lies, which I rejected. She was also highly dissatisfied that I, as the only speaker and not being a psychiatrist, had been asked by the organiser to give two talks.

The WHO has refused to grant methylphenidate the status of an essential medicine. In 2023, some clinicians and scientists echoed drug company parlance when they wrote in *Lancet Psychiatry* that this was a wrong decision arguing that the drug has a proven track record of efficacy and safety.[697] We explained why they were wrong.[698]

My research group has shown that FDA's approval of Purdue's controlled-release methylphenidate for adult ADHD was inappropriate, as the drug did not produce any meaningful clinical benefits.[699]

The textbooks direly warned of the consequences if ADHD is not treated with drugs. They were full of false claims that ADHD drugs improve educational and occupational outcomes and reduce the risk of accidents, emergency visits, crime, and drug abuse.[700]

The worst lies about ADHD drugs I have seen came in 2024 in the Evening Show on Danish national TV, funded by taxpayers.[701] It was a "feeling good together" session with a happy patient and psychiatrist Anne Philipsen who propagated numerous false statements, including that patients with an ADHD diagnosis die five years earlier if they are not treated with drugs according to a "very, very good Danish study."

Since this cannot be correct and I couldn't find any such study, I wrote to Philipsen. She did not reply but her practice manager referred to a book. I asked again, twice, but Philipsen still didn't reply. I therefore sent a complaint to Danish TV, which investigated the claim acknowledging that no such study exists.

One book claimed there is no evidence that psychotherapy works on the "neurologically conditioned core symptoms." This is scientific mumbo jumbo, and a Cochrane review of trials of psychotherapy showed an effect on core symptoms.[702] The book also said that the few large studies of psychotherapy all have methodological problems, citing a book by Marianne Geoffroy whose illogical thinking I described above (see page 145).

One book noted that a Cochrane review raised doubt about the effect of methylphenidate but added that it is indisputable that many clinicians and patients have experienced that the drug works. I see. Why bother to do randomised trials when we can just ask what the psychiatrists think?

Claims that placebo-controlled studies have shown an effect of stimulants in 70-80% of the children are bogus, as they ignore the spontaneous improvement. A Cochrane review – that it took nine years to produce after the protocol was published - showed some positive effects, but the results varied so hugely that it was wrong to meta-analyse them, and the authors could not determine if adverse effects did not occur, if the data had not been collected, or if they had been suppressed. The review was so bad that the criticism we[703] and others raised led to its withdrawal.

Two Cochrane reviews performed by my employees found that every single trial ever performed of methylphenidate was at high risk of bias.[704] Many of the studies were rigged,

either by dropping all patients who improve on placebo before the trial starts, or by studying only patients who have tolerated the drug before they are randomised to drug or placebo, or both.[705] The industry calls this an "enriched design." I call it a design that makes the industry rich. When given to adults, the drug had no effect on days missed at work, in contrast to textbook claims.

The drug regulators are remarkably gullible and uncritical. We showed that trials were missing in 7 of 13 applications for approval of extended-release methylphenidate in adult ADHD even though regulators require that all trials must be included in new drug applications. The median proportion of missing patients was a stunning 45%.[706] Paraphrasing Pete Seeger's famous song: *Where have all the patients gone? Long time passing.*

**The serious harms of ADHD drugs are ignored**

We showed that ADHD drugs impair reproduction in animals even after the drugs are stopped.[707] We also found that the reporting of harms in methylphenidate trials is extremely unreliable.[708] There are huge differences across trials that are impossible to explain, e.g. decreased libido was experienced by 11% in one trial and in 1% in a pooled analysis of three other trials.

As quality of life was measured in 11 trials but only reported in 5, where a tiny effect was found, quality of life likely worsens on ADHD drugs. If asked while their parents are not present, children they say they don't like the drugs, which is not surprising. Among harms, the textbooks listed headache, dry mouth, nausea, stomach pain, irritability, tics, mood swings, sadness, depression, nervousness, worsening of anxiety symptoms, sedation, increased blood pressure, insomnia, anorexia, and weight loss.

A study of 218 Israeli young adults using stimulants showed that 28% had tried to resist taking the drugs as children when told to do so by their caregivers.[709] Mood changes were observed among 66%, whereas the rate was only 0.01% in the package insert for Ritalin; 39% felt they were not themselves; and 3% had had thoughts of attempting suicide. A Cochrane review that had comparable control groups reported that methylphenidate increased the risk of serious adverse events (risk ratio 1.36), any psychotic disorder (RR 1.36), arrhythmia (RR 1.61), insomnia and sleep problems (RR 2.58) and decreased appetite (RR 15.06).[710]

The most serious drug harms received little or no attention in the textbooks. The only mention of withdrawal symptoms was in a book that noted that the symptoms can lead to decreased ability to drive, use machines and work. In contrast, a Cochrane review noted that people can experience severe withdrawal symptoms that can last for weeks, which include dysphoria, irritability, melancholia, anxiety, hypersomnia, marked fatigue, intense craving for the drug, and paranoia.[711]

Stimulants have hallucinogenic properties,[712] and some children develop mania or other psychoses.[713] Hallucinations involving visual or tactile sensations of insects, snakes, or worms are common.[714] In FDA's Prescribing Information for extended-release methylphenidate, the risk is stated to be 0.1%,[715] whereas in the UK drug agency's review, psychosis or mania occurred in 3% of patients on methylphenidate (versus 1% on placebo),[716] which is 30 times higher.

The psychiatric drug harms often lead to additional diagnoses, e.g. depression, obsessive compulsive disorder or bipolar, and additional drugs and chronicity.

One textbook noted that the drugs can cause mania and destabilise bipolar disorder, but not that bipolar is often misdiagnosed because of the drugs' harms. In 2015, I lectured at

Aalborg Hospital and professor of psychiatry Rasmus Licht lectured after me. I asked him how he could know, when he diagnosed bipolar in a patient who received an ADHD drug, that it was not just the drug harms he saw because they are very similar to the symptoms doctors use when diagnosing bipolar. I was flabbergasted when he said that a psychiatrist was able to distinguish between these two possibilities.

Psychiatrists usually ignore this fundamental problem and may even say that the drug treatment has "unmasked" the new disorder. This is one of the reasons why contact with the psychiatric system often leads to several diagnoses and polypharmacy and why temporary problems with mental health often become chronic.

It should be forbidden to make new diagnoses in patients on psychiatric drugs. If people get admitted to hospital in a psychotic state because they have taken cocaine, LSD or marihuana, we would not say: "Great, the drug has unmasked your schizophrenia!"[717]

Biederman played a leading role in the destruction of children. He and his co-workers made a diagnosis of bipolar in 23% of 128 children with ADHD and reported this as "an overlooked comorbidity?"[718] There is no overlooked comorbidity, only overlooked harms of ADHD drugs that resulted in a wrong diagnosis of bipolar in about one quarter of the examined children. The fact that doctors in America make this diagnosis in children 100 times more often than in the UK[719] illustrates it is a fake diagnosis in almost all cases and the extent to which American psychiatry is corrupted.

One textbook mentioned that abstinence reactions after stopping an ADHD drug can include depression, but even though the authors stated that the depression could increase the risk of suicide greatly, they advised to treat it with depression pills.

Death, the most severe harm, was never mentioned in the textbooks even though cardiac arrhythmias, myocardial infarction, stroke, and sudden death are listed in FDA's package insert for methylphenidate.[720] Stimulants double the risk of cardiovascular events,[721] and children have suddenly dropped dead.[722] That ADHD drugs can cause violence, suicide, homicide and death for other reasons[723] has also not received much attention. Psychiatrists do not think that deadly harms of their drugs are important information to convey in their textbooks to future psychiatrists.

In 2014, I was an expert witness in a much-publicised court case where Graham Bishop, an Englishman, almost stabbed his two daughters to death at Rigshospitalet. He was sentenced to 11 years in prison and permanent expulsion from Denmark, but the case was appealed.

The forensic committee acknowledged that methylphenidate could lead to "increased irritability and emotional instability" and that they could not exclude the possibility that the drug could have influenced his psychological state when the act was committed. But they considered it unlikely, arguing that he had previously taken similar doses without problems.

I told Bishop's lawyer, Karoline Normann, that he had never taken such a high dose before as the one he took just before the crime, and that even if he had not increased the dose, he could still have reacted out of character under the influence of the drug because the events that led up to the misdeed were very stressful.

As the harms of the drug are far worse than the committee's euphemistic note about "increased irritability and emotional instability," I wanted to see the committee's mental assessment of Bishop. The prosecutor refused, which I found unjust, as my role was to support the defense.

Via Normann, I asked the forensic committee if they considered it the standard of care that Bishop's psychiatrist had told him that he could increase the dose without problems and

with no upper limit. This question, and several others I posed, was ignored by the committee, and their reply to my question if they thought methylphenidate can increase the risk of violence, including homicide, was: "The question is of a general character."

What? It was very relevant for the case. I was highly uncomfortable with not getting answers and about the committee being in a position where it was essentially asked to evaluate its own previous judgment.

No one knows if Bishop would have committed his hideous crime had he not been on methylphenidate. Normann recently told me that he is completely normal today and that his surviving daughter sees him (the youngest one died; she suffered from a serious disease).

This is not the only time I have seen our forensic committee behave inappropriately. In Bishop's case, six of the ten members were psychiatrists, including Poul Videbech who, as I have explained, is unpredictable, arrogant, and unable to interpret science correctly. The committee's verdict is cut in stone, as if they were the Oracle of Delphi. No judge dares question it, and it cannot be appealed. This is unacceptable. Psychiatrists routinely deny the most dangerous harms of psychiatric drugs, particularly suicide and homicide.

It is an uphill battle to make people understand that ADHD is bogus because the indoctrination is so effective. I read in my newspaper in May 2024 in the sports section that a football player "had" ADHD, a "neuropsychiatric disorder."[724] If you look up neurological disorders on the Internet, you will find scaring diseases such as brain tumours, epilepsy, multiple sclerosis and dementia.

ADHD is not a neuropsychiatric disorder. It is just a name for certain behaviours. The invention of this non-thing is so harmful that it is beyond belief. The ADHD diagnosis should be banned; ADHD drugs are narcotics on prescription and should be removed from the market; people with symptoms that qualify for an ADHD diagnosis should receive psychosocial interventions or more stimulating schoolwork; triggers, such as poor parenting or poor schoolteachers, should be addressed; and the social structures that constrain parents and teachers from doing better should be addressed.

## Psychosis: pills are not needed and they are highly lethal

When chlorpromazine, the first major tranquilliser, appeared in 1954, it was considered a chemical lobotomy, as it produced many of the same effects and kept the patients under control, which was very popular with the staff in psychiatric wards.[725] It clouds psychiatric practice and research even today that the staff evaluate if the patients improve or not.

Psychiatrists observed that these drugs don't have any specific antipsychotic properties, but a famous trial of 344 newly admitted patients with schizophrenia funded by the NIMH in 1964[726] is still highly cited as evidence that the pills are effective. This is not what the study showed, however. The investigators reported, without offering any numerical data, that the drugs reduced apathy and made movements less retarded, the exact opposite of what these drugs do to people, which the psychiatrists had admitted a decade earlier.[727]

Patients with psychosis fare much better if they are not treated with neuroleptics,[728] but the organised denial is massive. In 2016, psychiatry professor Jan Ivar Røssberg from Oslo claimed that drug-free treatment lacks any support in science.[729] In 2017, he claimed in the Norwegian medical journal that neuroleptics work for most people; reduce mortality; and increase their functional capacity and quality of life. Without saying it directly, I implied in both media that Røssberg lied,[730] which he called my anti-psychiatric crusade.[731]

The chair of the Norwegian Psychiatric Association, Ulrik Fredrik Malt, claimed that my statements that antipsychotics kill many patients and prevent them from returning to a normal life were false.[732] However, a patient organisation supported me and criticised Røssberg and Malt for spreading fear, half-truths and lies, and for having very little respect for the users.[733] They noted it was a lie that most patients took psychosis pills voluntarily because many were threatened that if they didn't, force would be applied.

The textbooks tell us that the discovery of the drugs was a revolution; that many patients no longer need to live the rest of their lives in institutions; that many patients clearly improve their quality of life enabling their reintegration into society; that patients who were previously tortured by their disease and were aggressive can now live alone or in protected housing; that the number of hospital beds has decreased; and that most patients with schizophrenia will need lifelong treatment.[734] The textbooks also claim that the drugs work for negative symptoms, e.g. blunted affect, poverty of speech, asociality, and lack of motivation, and that they improve cognitive symptoms.

*All* of this is wrong. Moreover, psychiatrists are very poor in spotting the serious harms of their drugs. It took psychiatry 20 years to recognise tardive dyskinesia as an illness caused by doctors,[735] even though it is one of the worst harms of psychosis pills that affects about 4-5% of the patients per year.[736] It is a terrible movement disorder caused by brain damage, which is often irreversible but masked by ongoing treatment. There are videos of children and adults with akathisia and tardive dyskinesia showing how horrible these harms can be.[737]

Two books claimed that irreversible harms like tardive dyskinesia caused by first-generation drugs can be avoided by using second-generation drugs.[738] This marketing message is totally false.

**A meta-analysis of clozapine illustrates psychiatry's organised denial**

The textbooks considered clozapine (Leponex) the most effective drug for schizophrenia; some claimed it doesn't cause extrapyramidal symptoms; and some claimed it reduces mortality or suicides, or both. None of this is correct.[739] I have always been sceptical towards this drug and in 2025, my scepticism was confirmed when an individual patient data (IPD) meta-analysis came out in *Lancet Psychiatry* that compared clozapine with "second-generation antipsychotics" in people with "treatment-resistant" schizophrenia.[740]

I published a comment and a rebuttal of the authors' meaningless reply.[741] Their article starts this way (references omitted): "Introduction. In up to a third of individuals with an acute episode of schizophrenia, standard antipsychotic treatment does not lead to sufficient improvement of symptoms. Clinical guidelines recommend the use of the antipsychotic clozapine in such cases, because it is considered more efficacious than other antipsychotics, especially in people with treatment-resistant schizophrenia (typically defined as insufficient response to two trials of different antipsychotics with adequate dose and duration)."

There are six obvious problems with this.

First, it is highly misleading to say that up to a third of patients do not have sufficient improvement of their symptoms. Virtually all patients do not have sufficient improvement since, according to the last author himself, neuroleptics don't work. The least clinically relevant effect corresponds to about 15 points on the PANSS scale[742] commonly used in the trials. Yet, what was reported in the placebo-controlled trials of recent drugs submitted to the FDA was only 6 points, or 3% of the maximum score of 210 on this scale.[743]

Second, it is impossible for a clinician to decide if a particular drug has had an effect in a particular patient. No matter what the clinician thinks, it is extremely likely that there was no effect. The problem with clinical experience is that some patients will improve without any treatment, which clinicians erroneously interpret as an improvement caused by the drug.

Third, when the drugs are to blame, it is insulting to put the blame on the patients by calling them "treatment-resistant."

Fourth, a popular saying is that madness is doing the same thing again and again expecting a different result. Psychiatrists excel in this futile discipline, but it won't help trying another antipsychotic when none of them work.

Fifth, it won't help increasing the dose, as adding drugs or increasing the dose don't result in better outcomes.[744]

Sixth, an ineffective drug doesn't become effective if you take it for a long time.

In the Introduction, the authors write that clozapine should be used with caution because it has multiple harms - euphemistically called side-effects - which include weight gain, sedation, anticholinergic effects, and sialorrhea (which few people will know means excessive drooling). They also mention that clozapine can cause serious disorders, e.g. agranulocytosis (occurring in between 0.1% and 1% of the patients), myocarditis (between 0.01% and 0.1% of the patients), and seizures (between 1% and 10% of the patients).

How do you use a drug "with caution" that might kill you? It cannot be done, as deaths often come unexpectedly, e.g. because of cardiac arrest. Clozapine is more harmful than other neuroleptics, but all the drugs are highly lethal (see below).

So, what did the authors find and what is their message? They included 12 trials (1052 patients) and found a nonsignificant difference of -0.6 on the PANSS scale (95% credible interval -4.0 to 2.6) between clozapine and other neuroleptics. This is 0.7% of the median PANSS score at baseline of 91.5, corresponding to a standardised mean difference of -0.03.

The authors dismiss their own, very clear finding in several remarkable ways and give the reader the impression that clozapine, after all, is better than other drugs.

Under Results, they downgrade the confidence in the estimate of the primary outcome, the PANSS score, to very low: "The unavailability of IPD for some studies and the potential risk of small trial or publication bias, the frequent and partly differential premature study discontinuation of participants, and the fact that four trials included patients intolerant of previous antipsychotics" led them to this conclusion.

These arguments are not valid. Researchers or companies that are unwilling to share their data often have something to hide; the authors tested for publication bias and did not find it (P = 0.66); premature discontinuation is common in trials of schizophrenia and would not be expected to favour one drug over another when similar drugs are being compared; and intolerance to antipsychotics is very common, as these drugs are very harmful and unpleasant to take, so this should not be a reason to downgrade the findings either.

In the Discussion section, the authors present additional arguments for downgrading their findings to virtually nothing. They say that the uncertainty in the results arises from the fact that symptoms of schizophrenia fluctuate, which leads to uncertainty in imputation, and that their "adjustment for differences in duration of illness, baseline severity, and sex only incompletely explained the variance in results. These limitations, although partly mitigated by the use of IPD, led to a GRADE assessment of very low quality of evidence."

None of these arguments make much sense and they should not have led to a downgrading of the findings. Moreover, as I have previously explained,[745] it is wrong to use baseline severity as a predictor in a regression analysis. If you regress change in symptoms

on initial symptom severity, this corresponds to looking at (x − y) = ax + b, where x is the initial value and y the final value. Since x appears on both sides of the equation, 50% of the variation is already explained. This means that even when two factors are unrelated, the analysis will show a relation, which is spurious. The authors write that a higher baseline symptom severity was associated with a larger improvement in overall symptoms after 6-8 weeks. This is nothing but a mathematical artefact.

The authors use the UFO trick when they present a post-hoc analysis in the Results section of 7 trials (547 patients) for which they did not have individual patient data. In this analysis, clozapine was significantly better than other neuroleptics, standardised mean difference 0.24 (0.04 to 0.43). Meta-analyses of published data are not reliable but, curiously, the authors did not downgrade such unreliable evidence.

In their Discussion section, the authors mention another unreliable meta-analysis, in patients who were not treatment resistant, and note that clozapine was the "top-ranked drug based on efficacy, superior to all other second-generation antipsychotics, albeit based on a small sample size (n=270)."

Whether patients are treatment resistant or not, is immaterial, as all patients can be said to be treatment resistant for drugs that don't work.

The authors pull another rabbit out of the pharmacological hat, observational studies. They say that a meta-analysis of observational studies showed that "clozapine use was associated with lower risk of hospitalisation and all-cause discontinuation." As they admit that there could be systematic differences between patients receiving clozapine or other drugs that prevent causal conclusions, then why mention such studies at all? The UFO trick again.

Astonishingly, the authors write that "uncertainty remains regarding superiority of clozapine." Based on their meta-analysis, we can be certain that clozapine is not better than other drugs. The authors' conclusion is even more odd. They say that "In case of disabling symptoms despite adequate treatment with other second-generation antipsychotics, clozapine might then be considered, since other evidence suggests an advantage with clozapine."

I wonder why they did the most reliable meta-analysis ever and then so readily dismissed it, based on unreliable evidence? Was it to protect guild interests and financial interests in relation to the drug industry? What else could it be?

The authors also use psychiatry's eternal mantra, which is to rely on clinical experience even though it is useless when drugs don't work. They recommend to assess the effect of clozapine in the individual patients because "the superiority of clozapine in treatment-resistant schizophrenia is not certain."

Finally, they suggest carrying out "an adequately powered controlled trial in individuals with strictly defined treatment-resistant schizophrenia." As just noted, madness is to never stop doing the same thing, expecting a different outcome. No more trials are needed.

The abstract of a scientific paper is of utmost importance as few people read beyond it. This is where the authors explain what they did, what they found, and how they interpret it, in a very condensed way.

The authors write: "The confidence in the evidence was graded as very low." If our confidence in the best evidence we have - an individual patient data meta-analysis of the randomised trials – is so low, we might as well ignore all drug trials in psychiatry. Perhaps we should, but that is another discussion. I have called for introducing a new paradigm for testing psychiatric drugs.[746]

The authors seem to be influenced by Cochrane methods and the meaningless jargon that is now obligatory for people writing Cochrane reviews.[747] The abstract concludes that, "This IPD meta-analysis found a small and uncertain advantage of other second-generation antipsychotics." As the difference was not statistically significant and very close to zero, then why write that there was a small advantage when there wasn't?

The last sentence in the abstract warns that, "Given the side-effects of clozapine, the observed uncertainty regarding clozapine's superiority warrants prudent use." We cannot use lethal drugs prudently.

The conclusion of the new meta-analysis should have been: Don't use clozapine for any of your patients with schizophrenia. But this is not how psychiatry is. The meta-analysis of clozapine is a masterpiece in revealing what is wrong with psychiatry. When psychiatrists don't like their research results, they are not honest about the issues.

**The best guarded secret in psychiatry? Neuroleptics are highly lethal**

It is difficult to find out how many patients doctors kill with neuroleptics. In 2019, we could only find one placebo-controlled trial where the patients had not received such a drug earlier, from China.[748] It appeared to be fraudulent, with fabricated data.

Trials in schizophrenia are useless because virtually all patients are in treatment before they get randomised, and those switched to placebo are exposed to cold turkey effects, which increase mortality.[749] I therefore focused on elderly, demented patients assuming that few of them were in treatment before they were randomised.

I was shocked. Neuroleptics kill two patients for every 100 treated for about 10 weeks.[750] These drugs are some of the most toxic drugs ever invented. The lifespan for patients with schizophrenia is about 15 years shorter than for other people, but the psychiatrists put the blame on the patients and their disease. They very often use high doses or several drugs at the same time, which is serious medical malpractice, as it increases the risk of death without increasing any beneficial effects.[751] But the clinicians ignore this. A typical comment at conferences is: "The patient is doing well after two weeks on Zyprexa, so I doubled the dose."

Danish psychiatrists published a study concluding that the "risk of natural death" was not increased by using several drugs simultaneously.[752] It is not a "natural death" to be killed by a neuroleptic. And the mortality was doubled when the patients received three or more drugs instead of one. The authors removed this unpalatable result by adjusting for somatic comedication, which is a huge error because it partly reflects the additional harms by using many drugs instead of one.[753]

It defies reason why anyone would postulate that using many highly lethal drugs instead of one does not increase mortality, but psychiatry is pretty devoid of logic, and countless studies have been concocted to support the lie that psychosis pills *reduce* mortality, which two textbooks claimed.[754] All such studies have serious flaws.[755] Above all, the patients being compared - those on pills and others - are not comparable. "State of the Art" articles in medical journals are no better.[756]

Bob Whitaker once wrote to me that it requires extraordinary mental gymnastics by psychiatrists to conclude that these drugs, which cause obesity, metabolic dysfunction, diabetes, tardive dyskinesia, lethal cardiac arrhythmias, and so on, protect against death.

When, in March 2017, I tried to find out what kills young people with schizophrenia, I faced a roadblock, carefully guarded by the psychiatric guild. I described my experiences in 2017[757] but subsequent events were even worse.[758] Bob and I tried to find out why 12% of

patients with an average age of only 29 years died within 10 years after their first psychotic episode in the TIPS study. We asked the primary author and submitted a letter to *World Psychiatry* that published the TIPS results, but the editor, Professor Mario Maj, rejected our letter because "it does not compete successfully for one of the slots we have available." Six years later, I got the same robotic rejection note when I submitted another letter to Maj.[759]

How dumb we were to think that mainstream psychiatrists have any interest in helping young people survive by finding out what kills them. I appealed Maj's decision, calling on his professional and ethical duty to help the patients but he did not reply.

Psychiatry professor Merete Nordentoft was more forthcoming when I asked her about the causes of death for 33 patients after 10 years of follow-up in the OPUS study of patients with a first psychosis.[760] She sent a list of the deaths and wrote that cardiac deaths were not on the list but that she had seen in the death certificates that some patients had dropped dead, one of them while sitting in a chair.

We wrote to the funders of the TIPS study, and the Norwegian Research Council asked an investigator, Ingrid Melle, to supply us with details about the deaths. She sent me a table, which wasn't helpful, and her email raised new questions. Why did 16 young people (6%) commit suicide in just 10 years? And why was this vitally important information not explored by the researchers? We cannot conclude it was their schizophrenia that led to suicide. What was totally missing in the textbooks were the psychological harms psychiatrists inflict on their patients by taking away their hope of becoming healthy again, e.g. by telling them their disease is genetic, can be seen in a brain scan, is lifelong, and requires lifelong treatment with psychosis pills, all of which were claimed in the textbooks.[761]

Understandably, this increases the risk of suicide considerably. A Danish register study of 2,429 suicides showed a very marked dose-response relationship: The closer the contact with psychiatric staff, the greater the risk of suicide.[762] Most of the potential biases favoured the null hypothesis of there being no relationship, and an editorial noted that it is entirely plausible that the stigma and trauma inherent in psychiatric treatment - particularly if involuntary - might cause suicide.[763]

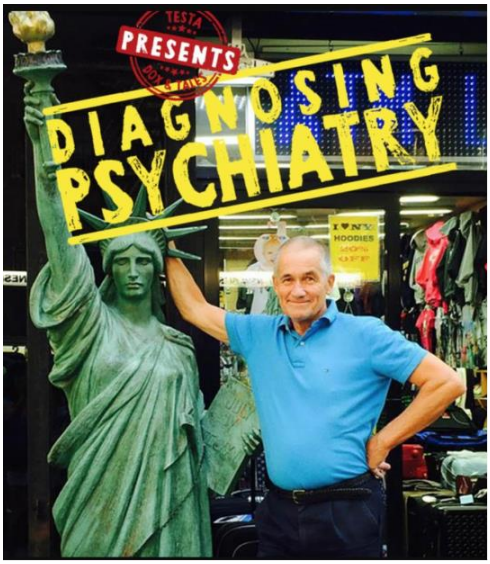
One textbook mentioned 10 risk factors for suicide, but admission to a psychiatric ward was not among them even though this seems to be the greatest risk of all. Furthermore, when psychiatrists take away the patients' hope of one day living a normal life, why should they then bother about having a healthy lifestyle? If life will never be worth living, why would they then abstain from smoking and drinking?

There were eight deaths from "natural causes" in the TIPS study, but it is not natural for a young person to die. I wrote to the Norwegian Research Council again but heard no more.

**Diagnosing psychiatry**

In 2017, Danish filmmaker Anahi Testa Pedersen launched the film, *Diagnosing Psychiatry*, about what I want to accomplish.[764]

I suggested this title because the film shows that psychiatry is like a contagious disease that can infect healthy people, which also happened for Anahi. She got the diagnosis schizotypy in 2009 when she became severely distressed over a difficult divorce. She jokes about the diagnosis in the film, and it is obvious that she should never have had a psychiatric diagnosis or been treated with drugs.




Anahi was deeply shocked to learn that although she had voluntarily contacted the psychiatric ward, the doors were locked behind her. At Bispebjerg Hospital they gave her quetiapine (Seroquel), a psychosis pill, and escitalopram (Lexapro), a depression pill.

When she questioned her diagnosis at discharge, she was told: "Here, we make diagnoses!"[765] The drugs doped her and made her indifferent, and she withdrew from them.

Another shock came eight years later when she received a letter from Psychiatry in the Capital Region. Believing that psychiatric disorders are hereditary, they wanted to examine her daughter. Anahi became angry. The letter stigmatised both her and her daughter who was well functioning, happy, healthy and had many friends. The summons came without her being asked about her course after discharge, or her daughter's situation and well-being.

Anahi phoned a psychiatrist at the department where she had stayed, but even though her family doctor had assured her that she was well and doubted her diagnosis was correct, she was told, when she asked for a re-examination: "The system doesn't do that!"

She was left with a lifetime erroneous sentence. This wouldn't have happened if she had been wrongly sentenced for a crime, but in psychiatry, this is "normal."

After many years of trying, she finally became de-diagnosed, in 2024, as the new diagnostic guidelines (ICD-11) allow this.

I had no idea what Anahi's monster was supposed to be, so I looked it up on the Internet and found a test for schizotypal personality disorder. The test was farcical and, as I have explained,[766] many, perhaps most, psychiatrists would test positive! Moreover, the test has an element of circular evidence. Healthy people might test positive when they have been treated inhumanely by psychiatrists, including being forcefully treated with psychosis pills.

This diagnosis, like most others, should be discarded. We should focus on the patients' problems, and not on a diagnostic system that is arbitrary, unreliable, and unscientific.[767]

A PhD student told me that when he described treatment options for schizophrenia, his supervisor requested he added a statement that psychosis pills have clear benefits. He strongly disagreed with this. His supervisor was president of the national psychiatric association and abused his position to protect his specialty's guild interests.

I advise patients that they should do everything they can to avoid getting treated with a psychosis pill, and ensure they can document they warned the doctor, e.g. by recording the conversation, bringing a journalist to the meeting, or demanding a written note on the spot,

not later. If doctors get in trouble, they often deny what happened and might even change the records.[768]

In the package inserts, the FDA warns against using neuroleptics in pregnancy because neonates may develop extrapyramidal and withdrawal symptoms including agitation, hypertonia, hypotonia, somnolence, tremor, feeding disorder and respiratory distress, sometimes needing intensive care unit support and prolonged hospitalisation. However, a textbook recommended to treat pregnant women with schizophrenia because untreated psychosis can endanger the life of the mother and child.[769] False. The pills *increase* this risk.

The textbook authors noted that FDA's warning *suggested* that the drugs affect the brain in both the child and the mother. This is ridiculous. We have *known* for 70 years that the drugs hamper normal brain functions, which is why they are being used, but according to Danish professors of psychiatry, it is only a *possibility* that psychosis pills affect the brain. So, if you are arrested for drunken driving, just tell the police that it is only a *possibility* that alcohol affects the brain!

**Lithium and antiepileptics**

Lithium is a highly toxic metal used for bipolar psychosis. It sedates people and renders them inactive, but psychiatrists praise the drug highly, saying it works and prevents suicide. In 2017, a Swedish psychiatrist in training, Joakim Börjesson, stayed with me for three months to research this issue. We were unable to draw any firm conclusions.[770]

Joakim considered leaving psychiatry after he realised, from reading books by Bob Whitaker and me, that he had been totally fooled during his medical studies. He had been told that psychiatric drugs were specifically targeted to work on a disorder's biological origin, which he found so fascinating that he decided to become a psychiatrist.

Most of the information on lithium in the textbooks was incorrect. One book, edited by Poul Videbech, claimed that lithium has a prophylactic effect in schizoaffective disorders and can dampen aggression.[771] However, a 2015 systematic review of 22 trials found no reliable evidence that lithium works.[772] In April 2022, I searched on *lithium schizo** in the title field on PubMed and did not find any additional trials.

One book claimed that lithium prevents suicidal behaviour in children,[773] but there is no evidence that this is correct. Three books claimed that lithium is neuroprotective, and two of them that the drug prevents dementia, with no documentation for this wishful thinking.

Antiepileptics are used for bipolar psychosis, and a lot else. The psychiatrists justify this by calling them "mood stabilisers," but they don't stabilise anything; they destroy people. Their main effects are to suppress emotional responsiveness by numbing and sedating people or stimulating them; they double the risk of suicide; and one in 14 patients develops ataxia,[774] which is a lack of voluntary coordination of muscle movements.

The clinical trials are characterised by massive fraud.[775] For lamotrigine, only two positive trials were published, while seven large, negative trials were not.[776] The FDA regarded the others as failed trials and approved the failed drug! A commonly used drug is pregabalin, with the seductive trade name Lyrica, but there is nothing lyrical about becoming sedated or euphoric, or killing yourself. The textbook Videbech edited claimed that some antiepileptics can be used for prophylaxis of bipolar.[777] There were no references, but systematic reviews do not support this claim.

## Dementia: the pills don't work and are harmful

How likely is it that a drug will slow down degenerative processes in the brain? Very close to zero. How likely is it that the drug trials are biased? About 100%. How likely is it then that the trivial effects measured on some rating scale in industry-sponsored drug trials that have not been effectively blinded are real and important? About zero.

At a meeting at my hospital, a clinical pharmacologist acknowledged that the drug effect is so small that it is irrelevant. But he added that the drugs could be tried because some patients respond better than others. With this argument, we could use anything that doesn't work. I told him a little about statistical variation. If the trial is repeated in the same patients, other patients will falsely seem to respond.

Imagine your old car is causing trouble and your mechanic tells you that his fix doesn't work, but that he hopes it will work for your car. Why is it so difficult for doctors to realise that the way they use drugs, they would not want their mechanic to copy?

Doctors start patients on ineffective drugs and see how it goes. In contrast to cars, many patients become better with time, and they then draw the false conclusion that the drug worked. Drug authorities are equally unreasonable. Numerous package inserts recommend trying a drug and see how it goes.

The textbooks are highly misleading.[778] *All* the claims about positive drugs effects were wrong, and there wasn't a single reference to placebo-controlled trials or meta-analyses. The books spoke of miraculous effects: acetylcholinesterase inhibitors can improve cognitive functions, apathy, hallucinations, delusions, other neuropsychiatric and psychological symptoms; can inhibit the progression of the disease for years; can lead to a resumption of earlier activities; and can reduce the decline in functional level and behaviour.

In 2022, journalists wrote in a newspaper that drugs "can slow down the development of dementia for up to a few years in many people." The journalists had been lied to by the professionals they interviewed, and I rebutted the lie.[779]

A 2006 Cochrane review of cholinesterase inhibitors concluded they are efficacious.[780] I pointed out in a comment published with the review that the improvement in cognitive function was 2.7 points, in the midrange of a 70-point scale, and less than the 4 points the FDA considers the minimally clinically relevant change.[781] The author wrote that "donepezil appears to have no serious or common side effects," which is so egregiously false that Pfizer would hardly have dared claim this themselves. The harms are common and serious, e.g. 29% of the patients dropped out when on drug, compared to only 18% on placebo. The most common harms listed in the package insert are nausea, diarrhoea, insomnia, vomiting, muscle cramps, fatigue, and anorexia,[782] not exactly what we would want for an old person who might already have some of these issues. The list of frequent harms is very long. Hypotension and syncope occurs in over 1% and when old people fall and break their hip, about 20% will die within a year. No benefits for society have been found,[783] which is interesting as we so often hear about the economic burden of dementia and how important it is to intervene with drugs, particularly from politicians when general elections come close.

A trial of 565 patients that compared donepezil with placebo, which - in contrast to the other trials was publicly funded - found no meaningful effects.[784] It was excluded from the Cochrane review with the invalid excuses that two dose groups were not reported separately and that "Complex design and high numbers of dropouts made analysis and interpretation difficult." As it was a long-term trial, a high drop-out rate was expected. The outcome after

three years was similar on drug and placebo for institutionalisation, progression of disability, and behavioural and psychological symptoms.

Six years after the trial was published, Pfizer's TV commercials implied that the patients' cognitive and daily functioning, attention, focus, orientation, communication, social interaction and engagement will be restored to normal; "Don't wait, talk to your doctor about Aricept."[785] I would say, "Don't wait, talk to your lawyer about Pfizer." The FDA told the company that - with its huge lies - it had broken the law.

The author of the 2006 Cochrane review, Jacqueline Birks, replied to me that an error had been corrected, but it was not corrected. In 2015, I was told that "An update of the review … is in preparation," but the review has not been updated. It stands as one of many gravestones over Cochrane, once a magnificent organisation, today in free fall (see chapter 14).[786]

Demented people are often treated with psychosis pills because they make them less disturbing. However, two doctors claimed in a textbook that neuroleptics have a documented effect in dementia. This demonstrated once again that clinicians are carried away by their "clinical experience." A chapter about psychopharmacology in the same book advised against neuroleptics because of their lack of effect and the risk of harms, including stroke.

So-called "State of the Art" articles in medical journals are usually highly misleading. In one such article, Peter Høgh, from a Regional Knowledge Centre for Dementia, wrote that several Cochrane reviews had shown that acetylcholinesterase inhibitors have an effect on cognition, activities of daily living, and neuropsychiatric symptoms, and that the loss of function is postponed for a minimum of 6-12 months. I explained in our medical journal that none of this is correct.[787]

Maybe we have too many doctors in the western world. I have not met a single geriatrician who didn't use dementia drugs. Prescribing drugs provides doctors with prestige, authority, and a meaning, and gives them something to talk about with the patients and their relatives. Like children, doctors cannot keep their fingers away from dangerous toys, which is why we should take all the ineffective and harmful dementia drugs off the market.

We should avoid drugging demented people and care for them instead. A systematic review of trials of agitated demented people showed large effects of care, e.g. communication skills training, activities, music, touch, massage and talking to people.[788]

## Electroshock: barbaric treatment that should be abandoned

Electroconvulsive therapy (ECT) "works" by damaging the brain.[789] Psychiatrists reported that ECT produced similar changes in the brain as physical trauma, in animals and people, with haemorrhages, particularly in the cortex, which in some cases led to permanent impairment of learning capacity, perception of reality, inventiveness, intuition and imagination.

Psychiatrists observed right from the beginning that patients lost their memories, which are what define us as humans, and made people confused. It took weeks to recover, and they often remained fatigued, intellectually impaired and disoriented, and acted in submissive, helpless ways.

The "effect" rather quickly dissipated, and the illness returned. ECT should therefore have been abandoned, but a perverse idea was invented: repeating the shocks numerous times. One textbook noted that ECT is extremely effective against severe depression, which agrees poorly with the information in the same book that, usually, 8-16 shocks are given.

Systematic reviews have failed to find benefits beyond the treatment period, both for depression and schizophrenia.[790]

But psychiatrists are highly skilled in the art of turning the facts upside down to sustain their harmful practices. It is worth remembering that they also described lobotomy and the many other barbaric treatments they used in the past in positive terms.

The descriptions of ECT in the textbooks were seriously dishonest. Two books noted that it is effective in 60-80% of the patients, which are meaningless statements, as there is no control group. Three books noted that ECT stimulates the formation of new neurons in the brain and considered this positive. They forgot to say that the brain reacts to brain damage by producing new neurons. There were no references in the textbooks and two of them were mendacious, as they claimed it has not been possible to detect brain damage even though it was shown already in the 1940s that ECT causes brain damage with necrosis in the brain in autopsy studies.[791]

ECT was particularly highly praised in the textbooks for treatment-resistant depression, and the denial of its harms was astounding.[792] Several authors ignored what the patients told them and claimed that it was difficult to know if the memory loss was caused by ECT or their disease, which is the standard script for psychiatrists: Blame the victim, not our treatments. In addition, the memory loss was trivialised, e.g. by talking about "inconveniences" and calling them "subjective" as if they didn't exist at all.

ECT causes memory loss in most patients, permanent memory loss in some, and kills some of the patients.[793] Many psychiatrists believe ECT can be lifesaving, which a textbook claimed, but there are no reliable data in support of this,[794] whereas we know for sure that ECT can be deadly. A systematic review found a death rate of about 1 per 1000,[795] which is 10 times higher than what the American Psychiatric Association and other organisations said. In April 2024, I interviewed the first author of this review, psychology professor John Read, for our *Broken Medical Science* film channel.[796] At a staff meeting, he raised the issue of a man who had died on the ECT table the day before.[797] The psychiatrist replied: "That is none of your business and I am personally insulted by your insinuation that we killed him." When John pointed out that the man's notes included "ECT contraindicated - serious heart condition," he was evicted from the meeting, physically. John and a colleague copied the notes, accurately predicting that the facts would quickly be removed from the file. He tried for two years to get the hospital, professional and governmental authorities to investigate but failed.

This experience spurred John's interest in ECT. He updated his review in 2024,[798] which confirmed that one death per 1000 was a reasonable estimate. He also found that between one in 15 and one in 39 people experience at least one of these events: myocardial infarction, life-threatening arrhythmia, acute pulmonary oedema, pulmonary embolism, acute heart failure and cardiac arrest. But the patients are told that ECT is safe and effective!

When I lectured in Brisbane in 2015, a woman said that the psychiatrists killed her son with ECT but resuscitated him. When he woke up, he had severe burns and the next two to three months he couldn't say anything people could understand. He is permanently brain damaged and his social skills are very poor; he cannot live on his own.

In 2003, the UK Royal College of Psychiatrists' fact sheet stated that more than 80% of depressed patients respond well to ECT.[799] This is how quacks argue, with no control group. The fact sheet also claimed that the memory loss is not clinically important. However, the memory loss is damning.[800] With a strict definition of memory loss, between 29% and 55% of the patients are affected. With looser criteria, the range goes from 51% to 79%.

A Danish patient couldn't even remember the name of the Danish capital, after she was electroshocked.[801] She was permanently brain damaged but was told it was her "disease" and not the shocks. She should never have received ECT. Her problem was that she had been sexually abused as a child. She didn't have any psychiatric disorder.

The psychiatrists who authored a Cochrane review of depressed elderly wrote: "Currently there is no evidence to suggest that ECT causes any kind of brain damage, although temporary cognitive impairment is frequently reported … ECT seems to be a safe procedure." This is dishonest. If the cognitive impairment was not caused by ECT induced brain damage, what caused it?

The 2010 official guidance for general practitioners in Denmark on depression stated that "Many have an unfounded fear of ECT treatment, although there is no evidence that the treatment causes brain damage; in fact, there is strong evidence that new nerve cells are formed in response to treatment."[802] As already noted, this is a sign of brain damage.

ECT is immensely unpleasant and frightening to patients; often elicits colossal bitterness and anger; and is perceived by patients as a serious breach of trust.[803] But in Denmark, forced treatment with ECT quadrupled in just seven years in the 1990s.

I have heard many stories about miraculous effects and grateful patients and, at a public meeting, I was once asked for my views about a woman who was so depressed that she could hardly be contacted but asked for a glass of water after ECT.

I replied with another anecdote. I examined a newly admitted man, an unconscious alcoholic, and needed to rule out meningitis. I tried to insert a needle in his back to tap cerebrospinal fluid for microscopy and culture, but it was very difficult and I hit his bone several times. All of a sudden, the drunkard exclaimed loudly: "Bloody hell, stop stinging me in the back!" Had I caused a miracle with my needle and cured the guy? No. Odd things happen in healthcare. Could I have woken up the deeply depressed woman with my needle? Who knows?

There is a moving documentary about Mette Askov, a Danish nurse I have met. She had heard voices since she was 8 years old and lost 15 years of her life to psychiatry.[804] She was diagnosed with paranoid schizophrenia and received vast amounts of medicine, 150 electroshocks and a disability living allowance. She was stigmatised and surrounded by prejudice but after she left psychiatry and reclaimed her life, she achieved some of her greatest goals. Her story illustrates what even when the psychiatrists' forced treatments clearly don't work, they continue using them.

Some psychiatrists I have met have never used ECT and some countries, e.g. Slovenia, don't use it. This barbaric treatment should be made illegal, just as lobotomies were. At the very least, no one should be forced to get ECT against their will.

Let me use a little irony. The apparent memory loss, or denial, for the psychiatrists is substantial and clinically important for their patients. If we want to know the truth about ECT and psychiatric drugs, we should therefore listen to the patients.

## Forced treatment: a license to kill

Only one of the five textbooks said anything substantial about this important issue.[805] It noted that the patients' aggression can be a reaction to conflicts with the staff, and that increased patient autonomy can reduce violent behaviour and the use of coercion. This respect for the patients lasted only one page. Next, we were advised that not using drugs for

patients who are agitated, aggressive, or violent should only occur exceptionally, and drugs against psychosis, depression, and anxiety, antiepileptics and ECT were suggested.

This "carpet bombing" is a license to kill and to make zombies. The book's argument that mentally ill people may lack the ability to give informed consent has been rejected by the United Nations' handicap convention that calls forced treatment unethical.[806]

The authors mentioned that benzodiazepines, amphetamines, anabolic steroids, and testosterone can cause motor restlessness and increase aggression. They did not mention that depression pills, methylphenidate, and psychosis pills can also cause such symptoms. Nor did they mention akathisia.

A power balance is needed in human relations, but involuntarily admitted patients are powerless and fear nothing more than forced treatment. This is a recipe for disaster. Some psychiatrists have electroshocked patients they disliked, and ECT has regularly been used for patients who were aggressive, restless, noisy, quarrelsome, and obstinate.[807]

The laws about coercion are problematic. In many countries, a person considered insane can be involuntarily admitted if the prospect of cure or substantial improvement of the condition would otherwise be significantly impaired. But drugs and ECT cannot cure or achieve substantial improvement. The other reason, that the patients present a substantial danger to themselves or others, is also invalid. The drugs can *cause* suicide and violence; they cannot protect against violence unless the patients are turned into zombies.[808] If people are dangerous, it is a matter for the police, which is the practice in Iceland. Studies have shown that, with adequate leadership and training of staff in de-escalation techniques, it is possible to practice psychiatry without using forced drugging.[809]

Many patients refrain from telling their psychiatrist certain things to avoid even more diagnoses and drugs. When asked if they have become better, they may confirm this even when the opposite is true. They quickly learn how to behave to protect themselves. This unhealthy therapeutic relationship reminds me of the living conditions in the concentration camps where it could be deadly to provoke the guards.[810] I was invited to Krakow when the Polish Medical Association in 2018 held their first meeting about medical experiments in the camps. I talked to a woman who miraculously survived the experiments in Ravensbrück, and to one of Oscar Schindler's girls. A tour was arranged to Auschwitz-Birkenau, which I also visited in 1981 when Poland was under Soviet rule. These are experiences you never forget.

If a patient says anything about having the dose reduced, she might have it increased, or might get an additional drug, with the argument that she lacks insight into her disease. I have received hundreds of emails from patients and relatives that describe this catch-22 situation. Some patients say they would rather be in prison.

A patient told me that the difference between a psychiatrist and a terrorist is that you can negotiate with a terrorist. Another patient said she likened forced treatment to rape and that there cannot be good rapes. She was raped by a man in her family when she was nine years old and became terrified when the staff subjected her to forced treatment.

Many patients, also in Denmark where this is illegal, have told me that they have been threatened that their sick pay or other social benefits could be taken away if they refused to take the prescribed drugs.[811]

The overriding question is whether forced treatment does more good than harm. I have no doubt it is very harmful. Mechanical restraint and ECT can be fatal; and, as explained above, psychiatric drugs and contact with a psychiatric ward, which often involves force, kill an enormous amount of people. It is therefore misleading when psychiatrists say that, were it not for the forced treatment, the patients might have died. Forced treatment kills.

One of psychiatry's failures is community treatment orders ("assisted" out-patient treatment, which is compulsory). A review didn't find any benefits of this,[812] and it also failed in clinical practice. After the UK had introduced it, hospital admissions increased,[813] with some areas discharging 45% of the patients with treatment orders, and others none at all.

*Mind* in the UK expressed serious concerns.[814] Many people who do not wish to take drugs for the rest of their lives are no longer able to make that decision. It is a catch-22 situation. If the patient remains well, this is taken to mean that the drugs are working, and if not, forced drugging is often increased, causing even more misery and more deaths. Many people consulted by *Mind* felt the professionals acted as "Mental Health Act police officers."

If you have acted like a cop and used force, it can be difficult to change that role into one as a healer and advocate for the patient. This is why psychiatrists should not act as police officers. Another reason is that violence breeds violence.

When I lectured in Australia in 2015, I was told that only 3-5% of the patients come off treatment orders. One doctor had been intermittently under such an order for 20 years. A psychiatrist had deemed him without insight because he had alerted the community to the brain-damaging effect of psychosis drugs! A psychiatrist I met was considered insane by her colleagues. She also spoke out about drug harms. They tried to have her involuntarily confined to hospital but failed.

Lawyer Jim Gottstein used scientific data to prove that coercion isn't beneficial.[815] He convinced the Alaska Supreme Court in 2003 to rule that the government cannot drug someone against their will without first proving that it is in their best interests and that there is no less intrusive alternative available.

But the psychiatrists and the judges don't respect the Supreme Court ruling. Nothing important has changed since the 1975 film, *One flew over the cuckoo's nest*. Jim wrote *The Zyprexa papers*, a book about illegal, forced drugging with psychosis pills that destroy the patients.[816] It describes how psychiatrists, lawyers, and Eli Lilly lied shamelessly, and that the judges didn't care. I experienced this first-hand as Jim's expert witness in Anchorage in 2016, which was described in a documentary film.[817]

I have argued extensively in books, articles, and lectures why forced treatment cannot be defended, either on ethical, legal, or scientific grounds,[818] and I co-authored a damning report with Jim and others in 2023.[819]

Jim is a hero. He ran a great personal risk by exposing Lilly documents supposed to be secret. I interviewed Jim and his wife, Nancy Rubenstein, on Maui in November 2023 for our *Broken Medical Science* film and interview channel.[820]

Since forced treatment is culture-based, it is no surprise that practices vary enormously between countries. Involuntary hospital admission is 20 times as common in Finland as in Italy.[821] In Austria, mechanical restraint is used 45 times more often than in Holland, where forced drugging is also used very little.[822] This is not evidence-based medicine.

People who argue for forced treatment and involuntary detention should read the book, *Dear Luise*,[823] which I have summarised.[824] Luise Christensen had autistic traits but functioned well. She was only 32 years old when she was killed by a neuroleptic at the Psychiatric Centre Amager. Luise's last request before she died was: "Mom, won't you tell the world how we're treated?"

If doctors consider becoming psychiatrists and can get through this book without crying, which I cannot, they should find themselves another job.

Luise's best friend, who stayed in the room next to her, suddenly collapsed on the floor and died within a few minutes. Luise was completely shattered and all she said to her mother was: "I shall be next," which came true six months later. She knew the psychiatrists would kill her. She survived for a while because she tolerated the overdosed psychosis pills so badly that she vomited most of them up. At last, they broke her defenses with a lethal injection of a depot drug.

Luise and her mother Dorrit had protested many times against the too high dose, but the level of ignorance, incompetence, and lack of respect for people who knew a lot about the drugs was huge. Dorrit did everything she could to prevent Luise getting overdosed. She was a slow metaboliser, and Dorrit had begged the psychiatrists never to use a depot injection.

Every year, on the anniversary of Luise's death, there is a demonstration in front of Psychiatric Centre Amager arranged by the organisation *Death in Psychiatry*, which Dorrit started. Sometimes there are around 20 relatives of the patients psychiatry killed.

The system's arrogance, both before and after her death, was unbelievable. When Dorrit complained to the authorities, they replied that Luise had received the highest standard of specialist treatment and congratulated themselves with their first-class homicide, which they called a "natural death."

Dorrit's book describes virtually everything that is wrong with psychiatry including making incorrect diagnoses that result in death. I know Dorrit and know that many patients are abused and die under similar circumstances as Luise.

Being treated humanely is difficult. If you panic and go to a psychiatric emergency ward, you will probably be told you need a drug, and if you decline and say you just need rest to collect yourself, you might be told that the ward is not a hotel.[825] This is bad medicine. Impending psychoses can sometimes be fended off if patients get the shelter and rest they need. There should be 24-hour support facilities without compulsion.[826]

The law is systematically being violated all over the world - even Supreme Court and Ombudsman decisions are being ignored.[827] I wanted to study this and got access to 30 consecutive cases from the Psychiatric Appeals Board in Denmark. Shockingly, the law had been violated in every single case.[828] All 30 patients were forced to take psychosis pills they didn't consent to, even though less dangerous alternatives could have been used, e.g. benzodiazepines.[829] The psychiatrists had no respect for the patients' experiences and views. In all 21 cases where there was information about the effect of previous pills, the psychiatrists claimed a good effect whereas none of the patients shared this view.

The harms of prior medication played no role, not even when they were serious. We suspected or found akathisia or tardive dyskinesia in seven patients, and five expressed fears of dying because of the forced treatment. An expert confirmed our suspicion that a patient had developed akathisia on aripiprazole (Abilify) but on the same page, the expert - a high-ranking member of the board of the Danish Psychiatric Association - recommended forced treatment with this drug even though it was stopped because of the akathisia!

The power imbalance was extreme. We doubted the psychiatrists' diagnoses of delusions in nine cases, but if the patients protest, they are told that they have a lack of insight into the disease, which is a symptom of mental illness. The abuse involved psychiatrists using diagnoses or derogatory terms for things they disliked or didn't understand; the patients felt misunderstood and ignored; their legal protection was a sham; and the harm was immense.

The patients or their diseases were blamed for virtually everything untoward that happened. The psychiatrists were not interested in traumas, neither previous ones nor those

caused by themselves or their staff. Withdrawal reactions were not taken seriously - we didn't even see this term being used although many patients suffered from them.

Jim and I wanted to do a similar study of 30 consecutive petitions from Anchorage but were met with so many obstacles that it took over four years of litigation before Jim was granted access to redacted records. With US psychiatrist Gail Tasch, I published our findings in 2023. Involuntary medication orders were requested in every case, and the legal procedures were a sham where the patients were defenceless.[830]

In violation of Supreme Court rulings, the patients' experiences, fears, and wishes were ignored in 26 cases even when they were afraid that the neuroleptics might kill them or had experienced serious harms such as tardive dyskinesia. Several psychiatrists obtained court orders for administering drugs and dosages that were dangerous, and the ethical and legal imperatives of offering a less dangerous treatment were ignored. The psychiatrists claimed, contrary to the evidence, that psychotherapy doesn't work. They never provided psychotherapy or family therapy.

It is a serious transgression of the law and medical ethics when psychiatrists exaggerate the patients' symptoms and trivialise drug harms to maintain coercion, but this often happens, and the patients' files can be misleading, wrong, or changed, e.g. after a drug induced suicide.[831] This way, the psychiatrists operate a kangaroo court, where they are both investigators and judges and, on top of that, they lie routinely in court about the evidence.[832]

When the patients complain about the harmful treatment, it is the same judges - or their friends who won't disagree with them - whose evidence and judgments provide the basis for the verdicts at the appeal boards. It doesn't matter what the patients say. As they have been declared insane, no one finds it necessary to listen to them. This system is so abominable that it looks surreal, but it is the reality all over the world.

Most patients on neuroleptics want to come off them, but as they are forced to take them, in the worst cases as depot injections to ensure they don't "cheat" by spitting out the tablets when the staff have gone, this is very difficult to accomplish.

The fundamental human right to equal recognition before the law applies also to people with mental disorders. This is clear from the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, and the United Nations Convention on the Rights of Persons with Disabilities, which have been ratified by virtually all countries.

In 2014, the UN Convention specified that member states must immediately develop laws and policies to replace regimes of substitute decision-making by supported decision-making, which respects the person's autonomy, will and preferences.[833] This means that unsoundness of mind and other discriminatory labels are not legitimate reasons for the denial of legal capacity. The UN's Special Rapporteur, Dainius Pūras, a Lithuanian psychiatrist, called upon all nations to make forced treatment illegal, but not a single country has done anything about it during all these years.

Recently, the UN called Pūras's work "ground-breaking," but psychiatric organisations were hostile and disdainful. Pūras and the UN were regarded as unscientific and biased, while current practice in psychiatry was presented as scientific and ethical, even though we heard about the usual falsehoods, e.g. that antipsychotics emptied the asylums and made it possible for people to live normal lives, and that drugs reduced the risk of suicide (without mentioning which drugs they were, but there are none), and with no references, only vague statements like "an extensive body of data."[834] That psychiatry is guilty of human rights

violations was called “absolutely slanderous as it attacks an entire professional community without distinction and - what is more - is absolutely not evidence-based.”

How long will we allow psychiatrists to continue with their lies, fatal mistakes, corporate denial, cognitive distortions, and suboptimal practice? It is our duty to free our citizens from this deadly violation of human rights.

In October 2023, the WHO and the UN Office of the High Commissioner for Human Rights issued a guidance.[835] Psychiatrist Niall McLaren wrote that, “at the slightest hint of a threat, the psychiatry/drug company axis will run squealing to their friends in government to drop a very large hammer on the upstarts … mainstream psychiatry world-wide will have a collective fit when they see what non-psychiatrists have planned for them ... given its record, institutional psychiatry will not give in with good grace ... the Guidance, as issued recently, is a gun pointing at psychiatry’s collective head.”[836]

Silas Dam killed himself in 2023, only 24 years old.[837] But in his short life, he made a contribution that will benefit Danish patients. He found that his belt restraint, approved by the district court and the high court, was unjustified and brought his case to the European Court of Human Rights in Strasbourg. This resulted in a settlement with the Ministry of Health obliging the government to amend the Psychiatry Act, so that the rights of psychiatric patients subjected to belt restraint were improved. His suicide note was: "Psychiatry killed me, belt restraint killed me, forced medication killed me ... Share my story."

Leading psychiatrists continue to ignore or distort the facts. The chairman of the Norwegian Psychiatric Association, Ulrik Fredrik Malt, claimed in a newspaper in 2019 that the risk of dying is six times greater if a patient with schizophrenia does not take neuroleptics.[838] I replied that I feel sorry for Norwegian patients who need to consult psychiatrists like him.[839] Leading psychiatrists have no shame about their monstrous lies, and I experienced this again in a court case in Oslo in 2024 where I was an expert witness.[840]

Erik Johnsen, professor of psychiatry in Bergen witnessed in support of the Norwegian state and claimed huge benefits of neuroleptics. He did not say where he got his numbers from, but I found out later: They were from the most flawed meta-analysis I have seen in my entire career. I had never seen a meta-analysis based on single treatment arms from randomised trials, all of which have at least two treatment arms. Without using the control group, anything can be shown to “work.” Which words shall we use to describe such fraud and contempt of court? Johnsen was instructed to be honest before he testified.

The judge acquitted the State even though she mentioned in her ruling an article where former Supreme Court Judge Ketil Lund and I argued why forced treatment with neuroleptics cannot be justified according to Norwegian law.[841] About my convincing testimony, she wrote that, “The plaintiff's witnesses are very critical of, or opposed to forced medication; their testimony was colored by this; and they spoke on a general basis.” Total nonsense.

We all work *pro bono* because we consider the case to be very important. We plan to appeal all the way, to the Superior and Supreme Courts, and, if we still lose, to the European Court of Human Rights in Strasbourg.

## Resistance towards withdrawing psychiatric drugs

Doctors have made hundreds of millions of patients dependent on psychiatric drugs without informing them of abstinence symptoms, and with no tapering plan.

Doctors learn a lot about starting the drugs but nothing about how to stop them safely. They may even feel disrespected when patients ask to come off the drugs they have instituted. A common remark in hospital notes is: "The patient doesn't want drugs. Discharged." It is like: "So, you don't like my drugs? Then you don't like me either. Goodbye!"

A patient told me she came on happy pills after a traumatic event without adequate information about their harms, and when she wanted to stop a year later, her psychiatrist said she needed a higher dose and warned her that stopping the drug could lead to chronic depression.[842] She became more and more lethargic and indifferent to everything. When her psychiatrist had long-term sick leave, she got support from a psychologist to taper off the drug she had been on for 3.5 years. When the psychiatrist returned, she was insulted that her patient felt much better without the drug and declared that she could not help her. This psychiatrist had a close relationship to a manufacturer of happy pills.

Patients are mostly left to fend for themselves and few can master this. They therefore share their experiences on the Internet, e.g. on theinnercompass.org created by Laura Delano, and on social media. What we need are withdrawal clinics, with easy and quick access free of charge, and education about the harmful effects of psychiatric drugs, how to stop them, and how to avoid starting them.

The advice in textbooks about how to withdraw patients from psychiatric drugs is mostly wrong and often dangerous. In long lists of withdrawal symptoms, the most serious harms, akathisia, suicide and violence, are missing.

None of the books explain that the binding curves for psychiatric drugs are hyperbolic and that the tapering therefore needs to be exponential, with very small dose reductions by the end.[843] The most important reason why withdrawal attempts fail is that doctors taper too quickly and in a linear fashion. Moreover, few doctors understand that withdrawal symptoms are not disease symptoms. When patients deteriorate, they are usually told that they still need the drug.

I invented the term "abstinence depression" for withdrawal symptoms that mimic a depression. It occurs when the drug is stopped abruptly or over a few weeks. Its hallmark is that the depression symptoms come quickly and disappear within hours when the full dose is resumed. Reintroducing the drug is therefore a diagnostic test separating an abstinence depression from a true depression. A trial showed that 25 of 122 patients on sertraline or paroxetine, who suddenly had their maintenance therapy stopped, developed depression whereas I calculated that the expected number of patients relapsing was zero.[844] Thus, they were likely all abstinence depressions.

The textbooks demonstrated that the psychiatrists confuse withdrawal symptoms with relapse. Two books claimed the patients do not become dependent on depression pills, and one noted that relapse should therefore not be misinterpreted as withdrawal symptoms!

Two books claimed that if the drug is stopped too early, it increases the risk of relapse, and recommended long-term treatment. A continuation phase of 6-12 months after remission of depression was advised, and the longer, the better, e.g. by severe depression with imminent suicide risk. This advice is deadly.

If a patient had had two depressions within 5 years, the doctor should consider continuing with the drug for an extra year; if three depressions, for 5-10 years or lifelong; if onset after 50-60 years of age, lifelong treatment because the risk of recurrence was said to be almost 100%. It was also claimed that an excellent preventative antidepressant effect is achieved. This cannot happen for drugs that don't work. One book recommended

continuing with the drug for the same number of years as the number of depressive episodes. Any higher bets for bizarre advice?

A big error was that the textbooks listed short time intervals where withdrawal symptoms can occur. They can occur any time, e.g. if the patients become stressed. A review found that the longer one is on the drugs, the higher the risk of withdrawal effects, which was 56% overall, with 25% of the patients experiencing severe withdrawal.[845] Another review reported that only one in six patients experience withdrawal effects,[846] but it was biased. Most studies were short-term industry-sponsored trials, which seriously underreport withdrawal issues.

In 2014, I co-founded the UK Council for Evidence-based Psychiatry at a meeting in the House of Lords.[847] It was established by filmmaker and entrepreneur Luke Montagu, heir to the Earl of Sandwich, who had suffered horribly from withdrawal symptoms for many years after he came off his psychiatric drugs.

When I arrived in Parliament, the Baroness came down and greeted me, and then the security didn't matter. My bag wasn't scanned.

In my lecture, I explained why the use of psychiatric drugs do more harm than good. We got a lot of press coverage, but three months later, I was heavily attacked by the silverbacks of British psychiatry in the very first issue of *Lancet Psychiatry*. Their article is full of *ad hominem* attacks and claims about miraculous drug effects, including that depression drugs protect against suicide and that people who criticise psychiatry are "anti-psychiatry."[848] It was very primitive, and I pointed out their errors and invalid arguments.[849]

These people were at the top of their profession and yet they held views in direct contradiction to the science. They claimed that SSRIs are some of the safest drugs ever made; that their adverse effects are rarely severe and that we should ignore "severe experiences to drugs," which they dismissed as anecdotes that might be distorted by the "incentive of litigation." They said the pills are highly effective in preventing recurrence, with a number needed to treat to benefit one patient (NNT) of around three. They did not understand that the trials did not assess recurrence but abstinence depressions in the placebo group. As only two patients are needed to get one with withdrawal symptoms when a drug is stopped,[850] there is no NNT to prevent recurrence, only a number needed to harm (NNH), which is two.

I mentioned Luke's name in 2015 in an invited article for the *Daily Mail* where I noted that psychiatric drugs are the third leading cause of death.[851] The UK Royal College of Psychiatry reacted the same day: "Sadly, articles of this nature can do more harm than good, as there is a real risk that they can discourage people from seeking or continuing treatment. This is dangerous, as untreated depression has roughly the same effect on mortality as smoking and can lead to suicide."[852] They urged me to publish my data in peer-reviewed journals so that the claims could be independently scrutinised.

What is wrong with publishing the data, which come from the published literature, in a book and do calculations on them? Moreover, it is misleading to say that untreated depression increases mortality when treating it with drugs increases mortality even more.

Luke wrote about his own psychiatric "career" in the *Daily Mail* article. His symptoms were of such a nature and severity that at first, I found it hard to believe him. I had never learned about anything remotely similar to his torment during my medical studies or later.

Luke had no psychiatric condition when he became a victim of psychiatry. He had a sinus operation and probably reacted badly to the anaesthetic, but his family physician told him

he had a chemical imbalance in the brain and put him on various depression pills. None of the psychiatrists listened when Luke told them it had begun with a sinus operation.

As it so often happens, Luke reluctantly concluded there was something wrong with him and every time he tried to come off the drugs, he felt so awful that he went back on them. After a psychiatrist had given him four new drugs, including a sleeping pill, he failed to realise he had become "as dependent as a junkie on heroin."

Luke was exposed to serious medical malpractice. At an addiction clinic, his psychiatrist advised him to come off the sleeping pill right away and within three days he was hit by a tsunami of horrific symptoms. This was the start of nearly seven years of hell. It was as if parts of his brain had been erased. When he recovered, he still had a burning pins and needles sensation throughout his body, loud tinnitus, and a feeling of intense agitation. When I last met with Luke, in June 2019, he was still suffering from withdrawal symptoms.

Luke founded the All-Party Parliamentary Group on Prescribed Drug Dependence (APPG), which successfully lobbied the British Government to recognise the issue and he also got support from the British Medical Association and the Royal College of Psychiatrists. In 2019, the APPG and the Council for Evidence-based Psychiatry published detailed guidance about withdrawing psychiatric drugs.[853]

Another of my colleagues, psychiatrist Mark Horowitz, would probably also have disbelieved the many horrible withdrawal symptoms his patients told him about, if he had not experienced similar horrors himself when spending years trying to come off his depression drug.[854] Mark wrote to colleagues that duloxetine, paroxetine and venlafaxine are vicious drugs to get off; that he had seen every possible horror from this including akathisia, muscle spasms, and suicide; and that it took 3-5 years for some people to come off them.

As Mark says, not telling people how they can come off the drugs is like selling a car without brakes.[855] When he stopped escitalopram, he would wake up in full blown terror, like he was being chased by a wild animal, and that terror would last for about 10 hours each day. He went running until his feet bled. As the terror didn't stop, he resumed the drug. He ended up on four additional psychiatric drugs to deal with the harms of escitalopram. After two decades, he is now down to a small dose of his last drug and will soon become drug free for the first time in 20 years.

Because of the overlooked withdrawal problem, I started an informal critical psychiatry network in Denmark with psychologist Allan Holmgren in 2014. Four of us wrote a short guideline, with an abstinence chart to record daily symptoms, and tips about how to produce very small doses. I made a list of people worldwide willing to assist,[856] and we helped patients in other ways, e.g. by telling them in newspaper articles that psychiatric drugs are not the solution to their problem.[857]

Nurse Helle Lengsholm from our network has described what happened when she spoke out about abrupt withdrawal with a fatal outcome.[858] At a nursing home, two depression pills were withdrawn from a resident shortly after she had moved in. She developed a pronounced withdrawal syndrome with restlessness, anxiety, hallucinations, abdominal pain, and nausea. Helle was called for an interview and was banned from documenting her observations and from contacting the doctor responsible for the disaster: "It is not you who is the doctor." The patient had dementia and could not express in words what she was experiencing. When she began screaming, a so-called safety box - a euphemism for killing patients with drugs - with diazepam and morphine was prescribed. This is usually only prescribed for terminal patients. The patient was not terminal but died after four days.

Helle reported the case to the Danish Agency for Patient Safety, which handled it, but did not inform her about the outcome. The outcome for herself was that she was fired.

In 2016, I co-founded the International Institute for Psychiatric Drug Withdrawal[859] in Göteborg, and in 2020, I published a book about surviving psychiatry and withdrawing from psychiatric drugs.[860] It has appeared in nine languages and was serialised on *Mad in America* where it can be read for free.[861] Volunteers have translated it into Spanish, French and Portuguese; these versions can be downloaded for free.[862]

It often requires strong determination and patience to come off the drugs. It can usually be done within a few months, but the record for psychiatrist Jens Frydenlund is eight years for an SSRI. He has worked with drug addicts for decades and says it is much easier to stop heroin than to stop a benzodiazepine or an. It is not surprising that some patients say the withdrawal was worse than their depression.[863]

Psychiatry harms the poor more than it harms the rich. Rich people can take time off work and pay for therapists helping them withdraw.

In Holland, former patient Peter Groot and psychiatry professor Jim van Os have taken a remarkable initiative. A pharmacy in Amsterdam produces tapering strips, with very small doses by the end, making it easier to withdraw: taperingstrip.org. Any doctor can order them. The results are impressive: Most patients on depression pills had previously tried to withdraw without success, but after a median of only 56 days, 71% of 895 patients had come off their drug.[864] In 2023, I wrote about this and explained how one can make small doses that are not commercially available without ordering tapering strips.[865]

The last small step can be the worst, not only because of physical issues but for psychological reasons: "I have taken this pill for so long; dare I take the last small step? Who am I when I don't take the pill?" The doctor may laugh and say it's impossible to have withdrawal symptoms when the dose is so low.[866] If such a "know-it-all" guy is involved in the withdrawal process, the patient should find another doctor.

The story of Stine Toft, a 27-year-old woman, is typical and so devastating that I published it.[867] She was only manic when she took a depression pill but got the diagnosis bipolar nonetheless. She was seriously harmed; was told her condition would last for the rest of her life. She also took antiepileptics and a psychosis pill; gained 50 kg; lost about 14 years of her life to psychiatry; lost her husband; came close to suicide; and ended up on disability pension.

Stine's next husband saved her. He asked what the sickness was all about, as he couldn't see it. But she now suffered from medication spellbinding. It took a year and a half before she agreed to withdraw the medication, which was excruciating because she didn't receive the necessary guidance. It took two and a half years to come off the drugs. Then, she found two of my books and realised that everything she had experienced was well known and perfectly normal. It was shocking to her to read that it is normal to be exposed to the hell she had been through but also liberating to discover that she wasn't sick.

Stine is well today. She became a coach and a psychotherapist and has helped many patients taper off their depression pills. She no longer sees her family. They had accepted the false claim that she was ill and just needed to take her medication.

Previously, Stine lectured for Psychiatry in the Capital Region about being bipolar, which was easy. People like to see a sick person and hear her story. But a psychiatric survivor's success story that calls the whole system into question is too threatening for the profession.

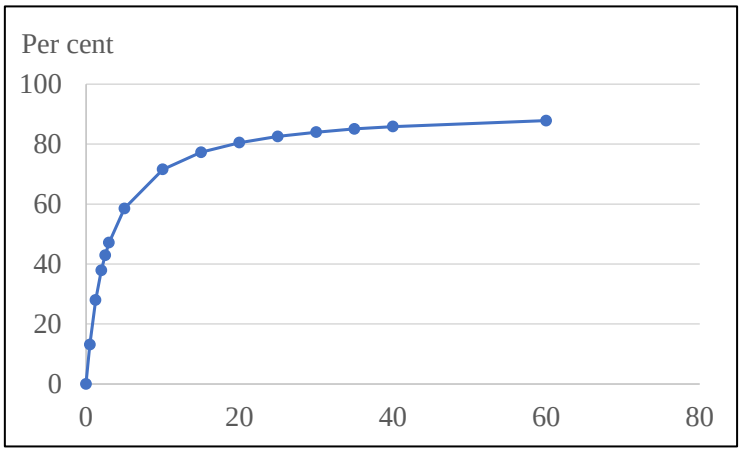
In 2019, Stine suggested to the patient organisation "Better Psychiatry" in her hometown that they invite me to lecture. The chair didn't know who I was and introduced the meeting

by saying that psychiatry needed more money. I said I wasn't sure this was a good idea. If more money came in, even more diagnoses would be made, even more drugs would be prescribed, and even more people would end up on disability pension.[868]

It was worthwhile to write the book about withdrawal. The first chapter is: *This book might save your life*, and I received many emails telling me it had saved someone's life.

Most doctors know very little about the issues,[869] and the authorities are not any better. In 2019, the Danish Board of Health issued a guideline about depression pills to family doctors. The sender was *Rational Pharmacotherapy*, but it wasn't rational, it was dangerous. As I knew from earlier experience that you get nowhere by complaining to the authorities, I warned people against the guideline in a newspaper.[870]

The Board of Health was given the opportunity to respond but declined - a sign of the arrogance at the top of our institutions. A psychiatrist and a clinical pharmacologist had contributed to the guideline, but they didn't seem to know that binding curves for drugs to receptors are hyperbolic even though we learn this at medical school (numbers on the x-axis are citalopram doses):




(Courtesy of Mark Horowitz)

The curve is very steep in the beginning when the dose is low, and it flattens out and becomes almost horizontal at the top. Citalopram is recommended to be used at dosages of 20 or 40 mg daily, but even at a dose as low as 0.4 mg, 10% of the serotonin receptors are still being occupied.[871] This means patients may experience withdrawal symptoms when they go from that small dose to nothing.

The Board recommended halving the dose every two weeks, which is risky. It is also too fast to lower the dose every two weeks.

The principles about hyperbolic withdrawal have been known for decades and my colleagues and I have written about them in Danish newspapers and elsewhere since 2017.[872] In 2019, eight months before the Danish Board of Health published its guideline, they were explained in an instructive paper in *Lancet Psychiatry*.[873]

In 2021, psychiatrists Christoffer C Lundsgaard and Poul Videbech nonetheless advised to halve the doses every second week in a "State of the Art" article in our medical journal. I explained again why this advice is dangerous.[874] In their reply, they changed subject and noted that I arranged "expensive" (they were cheap) courses in withdrawal and that I sold books (I only wrote one) about this.[875]

Without psychiatric drugs, psychiatrists would be pretty naked, as few of them can practice psychotherapy. So, when you tell people the truth about the drugs and lecture about how patients can withdraw from them and get a better life, there are huge push-backs from the psychiatric guild and its allies in the drug industry.

I lobbied speakers on health in the Danish Parliament for over ten years and they were always positive when I explained why major changes are needed in psychiatry. But they never dared challenge the psychiatrists who were quick to tell them it was outside their area of expertise. It is also convenient for politicians that there is a profession that deals with the most disturbing elements in our society and control them.

In 2016, there was a hearing in Parliament about why withdrawal from psychiatric drugs is important and how we should do it, which was the title for my talk. The only psychiatrist on the programme was Bjørn Epdrup who said that psychosis pills are needed and that he could see schizophrenia on a brain scan. This was bollocks,[876] but Epdrup left the meeting before anyone could confront him with his claims. The only thing that can be seen on a brain scan is the shrinking of the brain that psychosis pills have caused![877]

In 2017, I gave an invited talk at a meeting about overdiagnosis and overtreatment in psychiatry in Sherbrooke, Canada. Even though most of audience were psychiatrists, 74 of the 84 participants reported afterwards that my presentation had responded to their needs. I had not expected this, particularly not after the discussion, which was tense.

I felt a change was on its way. Two months later, Allan Holmgren and a political party arranged the conference, *A psychiatry without drugs*, in Parliament. Bob Whitaker lectured about the psychiatric drug epidemic, and I exposed the myth about biological psychiatry.

Nothing changed. The bad business continued. Later in 2017, I held a full-day course about psychiatric drug withdrawal in Copenhagen. This was too much for the believers in biological psychiatry. *MIND*, the member journal of the most influential organisation for psychiatric patients in Denmark, refused to publish my submitted ad for the course even though it was both for professionals, patients, and their relatives.[878]

I called *MIND*'s journalist, Henrik Harring Jørgensen, who was responsible for ads. He was very uncomfortable and said he shouldn't get involved in the debate about psychiatric drugs. I explained that whatever one thinks about psychiatric drugs, many patients wanted to quit, but couldn't get any help, which was why we offered the course.

Jørgensen needed a green light higher up, and I knew that *MIND*'s chairman, Knud Kristensen, was very fond of drugs, which he always praised in the media when I criticised them. In a radio debate, he argued that some of his members had said that depression pills had saved their life. I replied it was an unfair argument because all those the pills had killed couldn't raise from their graves and say the pills killed them. When I lectured for *MIND* in Copenhagen a year earlier, Kristensen had travelled from the other end of the country to chair the meeting and to ask questions. He clearly disliked me, and his questions were unfriendly. However, the patients said that what I had told them was true, and they had experienced themselves how difficult it is to stop psychiatric drugs.

*MIND*'s headquarters ignored me. I sent several emails they didn't respond to and called several times and was switched to Jørgensen by the secretary who said he was in his office, but he didn't pick up the phone when it was me.

When the deadline for the ad was only a few days away, I went to *MIND*'s headquarters to get an answer. Documentary filmmaker Janus Bang had followed my work for two years, so I took him and his crew with me to record the event for later use. We did not announce our visit in advance, of course.

*MIND*'s director, Ole Riisgaard, treated me very rudely and condescendingly, like when a school master reprimanded a naughty pupil in the 1950s. He knew about my ad but needed Kristensen's approval.

The next day, he wrote they would publish my ad. He added that, "Considering your very bad and totally unacceptable behaviour yesterday where you showed up without agreement or permission, and with cameras turned on filming *MIND*'s staff, several of whom are mentally vulnerable and employed under special provisions, the condition for bringing the ad is that you, before the deadline, will send me a written (signed) guarantee that none of *MIND*'s employees will participate in any kind of broadcast without written consent."

The cameras were not turned on, and we had been calm and polite. The only people displaying bad behaviour were Riisgaard and Jørgensen, which we recorded with a hidden microphone, as we find it important to document bullying and abuses of power in matters of importance for patients' health and survival. Janus wrote to Riisgaard that he had asked for permission to film, which was granted, and as soon as this was rejected on another floor, the film work stopped. The only one who was filmed was me.

I wrote to Riisgaard that since Jørgensen never replied, we had no other option than to visit *MIND*'s headquarters. To his explanation that the reason I did not get a reply was that *MIND* was busy, I replied that it would have taken Jørgensen a few seconds to respond OK when I sent him the ad. I also wondered why *MIND* would not give a helping hand to the many of their members who wanted to stop taking drugs but had been unable to get any help from their doctor.

The day before our visit, Riisgaard received an email from a local branch, secretly copied to me, explaining that they had discussed my correspondence with Jørgensen about the ad: "It looks as if some form of censorship is being applied. It is our impression that many of our members are interested in Peter Gøtzsche's work. We do not understand this attitude."

So, what do leaders do when they won't admit they don't give a damn about their members? They don't respond, or they lie. Riisgaard lied arrogantly: "Gøtske [sic] has not been denied the opportunity to advertise. If he gives another impression, it is just to make himself interesting." Why is it that I constantly run into very primitive people?

In 2016, some members of the local branch had wanted to invite me to give a lecture, but the proposal was voted down. I replied that I found it sad and noted: "A patient association should have an open *MIND* and should not close the door when researchers have come to different conclusions about the drugs than what you hear in the marketing messages. I am also amazed that so many in the healthcare system, including patient associations, are so incredibly paternalistic and patronising and do not believe that patients are best able to assess their own situation, and are also usually able to discern sensibly when they hear opposite perceptions of things. It's actually scary to me. At the same time, we hear everywhere that the patient must be at the centre. I am sending you my book in the hope that you might still feel tempted to get an insight into how it can be that I have reached quite different conclusions about psychiatric drugs than the usual narrative."

I heard no more. The most influential organisation for psychiatric patients in Denmark is more interested in being on good terms with the psychiatrists and the drug industry than in helping their patients.

The psychiatric guild doesn't want to help patients withdraw either. I had informed Psychiatry in the Capital Region about our course explaining that I collaborated with skilled psychiatrists, psychologists, and pharmacists in several countries, and with many patients with ex-

tensive experience in withdrawal. The lecturers included a child and adolescent psychiatrist, a psychologist, and two pharmacists, one of whom was also a psychiatric survivor, all with expertise in the subject.

Three days later, Poul Videbech complained to the Patient Safety Authority: "A Peter Gøtzsche, a specialist in internal medicine, has arranged the course below for patients and others. I believe of course that he takes on a colossal responsibility that he has no knowledge at all to bear. Can doctors just do this kind of thing without having the necessary factual knowledge? Moreover, it is private entrepreneurship, which abuses the Cochrane Centre's name."[879]

Videbech is an arrogant bastard. "A Peter Gøtzsche" suggests I am unknown, but I was very well known by Videbech and the Authority. I wrote to Videbech that he should have cheered instead of reporting me to the Board: "Finally, there is one who does this. Although hundreds of thousands of people in Denmark are dependent on psychiatric drugs, the psychiatrists have never held such a course. They have failed their professional responsibilities. They don't even care about how best to taper off."

The Authority didn't take Videbech's complaint seriously. After four months, they asked me which qualifications or experiences I had with individual withdrawal of psychosis pills, and I replied that this was not relevant because the purpose of the course was that we should learn from each other, including hearing about the patients' experiences.

I was also asked what role the Nordic Cochrane Centre had in organising the course. As there was no mention of the Centre in the announcement, I didn't reply to this question, which was irrelevant and beyond the Authority's control tasks. Later, they asked for information I had already sent to them, and four days after we had held our course, they declared they would not take any action.

I uploaded videos of our lectures and other information.[880] We held several other meetings for the public and I gave many lectures about withdrawal, in several countries.

In 2017, psychiatrist Jan Vestergaard tried to get a two-hour symposium about benzodiazepines on the programme for the annual meeting of the Danish Psychiatric Association. Even though the meeting lasted four days, with parallel sessions, the board said there wasn't room for the symposium. I was scheduled to talk about withdrawal in general.

I called the conference hotel in Nyborg, booked a room for 16 March 2018 and held a two-hour symposium for the psychiatrists in the morning, which we repeated in the afternoon, with no entrance fee.

Professor of clinical microbiology, Niels Høiby, interfered with our altruistic initiative, which was weird, as bacteria have nothing to do with drug withdrawal. He is evil. He accused Helle, my wife, of scientific misconduct when she was preferred for a professorship rather than his own protégé. The accusation was groundless and ridiculous, and reflected nothing but his oversized ego. Helle had presented a poster at a congress, and Høiby complained that none of his research was cited. But it was irrelevant, and Helle was promoted.

Høiby was elected for a conservative political party, Liberal Alliance, in the region. He raised a so-called political question mentioning that I had written a book on the use of psychiatric drugs and conducted courses to get patients to taper off their drugs.[881] He asked if my hospital's board, the Capital Region, and the Health Council for Psychiatry, had asked the region's psychiatrists and general practitioners if they supported or distanced themselves from the activities of the Cochrane Centre's director regarding the use of psychiatric drugs.

Høiby has a habit of copying numerous people on his ravings. The answer is as interesting as Høiby's malignant question. Psychiatry in the Capital Region declared that they had informed all their centres about the activities he mentioned; were critical of my offer; and had requested that attention be given to patients that might accept the offer. Moreover, they noted that several department heads and professors had publicly expressed their disagreement with me and my activities, e.g. at the event *The art of discontinuing a drug* organised by the Capital Region and at a public debate about psychiatric drugs organised by Psychiatry in the Capital Region: "At both events, Peter Gøtzsche himself participated."

Oh dear. The man "himself" showed up and even dared ask questions. Obviously, it is unacceptable for the establishment that I try to meet the needs of the patients when the psychiatrists don't want to, even though the establishment constantly talks about putting the patient at the centre of their activities.

I advertised the symposia in our medical journal and psychologist Anders Sørensen, one of my PhD students who was researching withdrawal, also lectured. Later, when we strolled around, we learned that the young psychiatrists had been scared away from attending because their bosses would see them as heretics and might retaliate. Only seven of the 60 participants identified themselves as psychiatrists, but there were likely at least eight more who did not dare give their background.

Other health professionals have told me similar stories about receiving dire warnings from their superiors that if they showed up at my courses or lectures, it would not be well received at their department. This is frightening and diagnostic for a specialty that behaves more like a religious cult than a scientific discipline. In science, we are keen to listen to new research results and other points of view, which make us wiser.

The symposia were a success. The most experienced psychiatrist in the room told one of his junior colleagues that I dwarfed leading psychiatrists. Which is why they didn't want their junior doctors to listen to me. It might become too difficult for themselves when they came back and asked questions about why patients needed to be in treatment for years or decades instead of being phased out and having a better life. There is a video summary of our lectures.[882]

Three months after our two symposia, we held a research seminar in Copenhagen. Laura Delano presented risk-reducing taper protocols and pharmacist Bertel Rüdinger from our group also lectured. Psychiatry had stolen 14 and 10 years of their lives, respectively, and had caused both to come very close to suicide.

Bertel died suddenly in 2021, only 47 years old, from a thrombosis. His psychosis pills had made him very obese, and after he came off them, he was unable to lose weight. It is likely that psychiatry killed him and took 30 years of his life.

"You too, Bertel," we said.

On 24 February 2018, Wendy Burn, president of the Royal College of Psychiatrists and David Baldwin, chair of its Psychopharmacology Committee, wrote in *The Times* that, "We know that in the vast majority of patients, any unpleasant symptoms experienced on discontinuing antidepressants have resolved within two weeks of stopping treatment."

Nine clinicians and academics, me included, wrote to Burn and Baldwin that their statement was incorrect and had misled the public on an important matter of public safety. We noted that the College's own survey of over 800 patients, *Coming off antidepressants*, found that withdrawal symptoms were experienced by 63% and that a quarter reported anxiety lasting more than 12 weeks. We added that within 48 hours of publishing their misleading

statement in *The Times*, the College had removed this document from its website. So, as soon as we sent a complaint to them, the College took down the survey that totally contradicted their claim. We asked Burn and Baldwin to retract their statement or provide supporting research. Baldwin sent two company-funded papers with himself as first author.

We then sent a formal complaint to the College, signed by 30 people, including ten who had experienced withdrawal effects for one to ten years, and ten psychiatrists and eight professors.[883] When the College refused to correct the error, claiming there was none, we went public, and the *BBC*'s Radio 4 programme, *Today*, covered it on 3 October 2018. The College refused to participate in the programme.

Later, the Royal Society of Medicine launched a podcast series where the opening topic was depression pills and withdrawal. Psychiatrist Sir Simon Wessely, president of the Royal Society of Medicine (and recent president of the College) rejected any link between the pills and suicide and stated categorically that the pills are "not addictive."

As people wouldn't listen, we published a damning letter in May 2019 in the *BMJ*.[884] When the College claimed that withdrawal effects lasted only two weeks, they referred to guidelines from the National Institute for Health and Care Excellence (NICE) stating that withdrawal symptoms were "usually mild and self-limiting over about 1 week."

We sent a freedom of information request asking for the evidence. NICE provided only two short review articles, neither of which supported the one-week claim. Both articles cited numerous sources that contradicted it.

The embarrassment was now so big that the College needed to change its stance. Public Health England published an extensive evidence review with important recommendations, including a national 24-hour helpline and withdrawal support services.[885] And NICE updated its guidelines in line with the evidence the following month.[886]

But there was very little progress. Four years later, we published an open letter in *BMJ* saying the government has a moral duty to help those harmed by prescribed dependence forming drugs, which are used by one-quarter of the population.[887] We were frustrated that, instead of helping alleviate this enormous problem, which was very expensive for society, the government had in fact made the situation worse.

I agreed with Anders Sørensen that he should mentor 30 consecutive patients who turned to us for help with withdrawal, no matter which drugs they took, and write about it because there wasn't a single such paper in the literature.

We reasoned we'd better handle this "heretic" idea with utmost care and therefore submitted a protocol to the research ethics committee. We did not want to do a randomised trial because withdrawal is a highly individual process, but we ran into a formidable roadblock. The committee responded that, although two experienced psychiatrists were involved with our project, there was no clear description of who was responsible for drug withdrawal, which, for reasons of patient safety, must be a psychiatrist.

An interesting remark considering that a member of the committee was a psychiatrist working at Psychiatric Centre Amager that killed two patients with psychosis pills within a short time interval because of incompetence (see page 175).

We could not see why, for reasons of patient safety, a psychiatrist must be responsible for the drug withdrawal, and it was not a legal requirement.

To assess if our study was safe for the patients, the committee asked us to do a literature review on the suicide risk for such patients. Well, as most drugs *increase* the suicide risk, it is a good idea to take people off them!

We were asked how we could ensure that only patients who tolerated drug withdrawal would be withdrawn in the study. This was a catch-22. No one - psychiatrists included - would be able to ensure this.

The other demands were also unreasonable. We would need to use more specific inclusion and exclusion criteria and explain which endpoints we would use and if our questionnaires were validated and made it possible to draw reliable conclusions. This was nonsense. Our endpoint was if the patient became medicine-free, which does not require validated questionnaires.

We also needed to add a lot to the patient information. When a research ethics committee believes it is so dangerous to help patients come off their drugs, then why were the drugs approved in the first place? Aren't they too dangerous to use? This is the logical conclusion, but healthcare is not about logic; it is about power and money.

After the committee had killed our project, I called a lawyer at the committee and told her that we could just withdraw the patients as planned, without calling it research. She didn't have issues with this, so we went ahead, and still intended to publish our results.

What makes all this particularly ridiculous is that research ethics committees approve many highly unethical trials that randomise patients to a cold turkey. When I looked up clinicaltrials.gov and searched on depression and taper, the first trial I found, NCT02661828, compared a two-week with a one-week taper. This trial was unethical for *all* the patients. It was sponsored by Emory University, notorious for a huge corruption scandal. When whistleblowers reported to the university that millions of drug industry dollars had changed hands secretly for more than a decade, at least 15 whistleblowers were ordered psychiatric evaluations by Emory's psychiatrists - including one of the perpetrators, Charles Nemeroff, who wrote up exams without examining the targeted doctors or gathering factual evidence, after which several of them were fired.[888] Psychiatry on the rocks.

## The personal attacks peaked in 2017 and 2018

The most mendacious and evil journalist I have ever been exposed to is Danish Kristian Lund who publishes drug industry supported magazines on the web. He wrote in 2017:[889]

"Peter Gøtzsche is powerful. From his position as an unprecedented autonomous Director of the Nordic Cochrane Centre, he has over the years made politicians change their attitude, thwarted ambitious health plans, got the patients on the barricades and provoked the drug industry ... he is sovereign when it comes to managing the press and public opinion. He speaks in headlines. Masterminds the criticism from which the media creates sensations. Evidence or not. In campaigns with an often-unprepared press, Peter Gøtzsche runs hard on medical colleagues who have the slightest relation with the drug industry."

No surprise that so many people in so many countries tried to eliminate me.

Lund got access to my financial records three years back in time, and his team worked hard on finding something on me. When they didn't, they lied. They wrote around 20 articles and sent drafts for the first five for my review, which Lund and Nina Vedel-Petersen published in 2017. I counted 63 untruthful statements in the drafts, and after I had consulted with my hospital, I sent this message, which they published in one of the articles:[890]

"I have observed that, according to §267 of the Criminal Code, the (articles, ed.) are libellous and express slander. They are affected by so many untruths, speculations, and distortions that it would make no sense to comment specifically on them. They are basically not source-based. On this background, I do not wish to contribute with concrete comments."

The untruthful articles continued unabated, also after my hospital had declared that they had not found any confusion of private money, government grants and other funds, which was printed in one of the articles.[891]

In February 2018, I complained to the Press Council, which reprimanded Lund nine months later. I noted that it looked like a carefully planned campaign which ultimate purpose was to close the Nordic Cochrane Centre and get me fired, and that many of the allegations were malicious lies, because my hospital, in extensive email correspondence, had informed the journalists in advance that they were wrong.

Lund succeeded in convincing many people that I had done something wrong. He and his colleagues presented their lies already in the headlines:

- Liselott Blixt: Highly critical that Gøtzsche uses Cochrane money on marketing his own books.
- "It is painful and disturbing if Cochrane loses its credibility."
- Gøtzsche uses Cochrane money to promote private business.
- PR tours at the state's expense.
- Private website for public funds.
- Private insurance - paid by the public.
- Private profits at the taxpayer's expense - is this allowed, Gøtzsche?
- Expert: Tax problems if Gøtzsche's book promotion is covered.
- Danish Cancer Society: Cochrane deliberately manipulates and misleads Danish women.
- The stray Cochrane Centre and its unruly boss.

Blixt was very important for me, as she chaired the Committee on Health in parliament. She said in the article that I could get dismissed if I failed to distinguish between my own money and taxpayers' money. Another politician threatened with reducing our funding. And those who had been interviewed represented the majority in parliament.

Because of all the lies, I needed to do a lot of fire extinguishing. I contacted Blixt, and she realised she had been fooled by Lund. One lie was that I had travelled to Australia on first class. Another that my hospital paid for an extra night when I participated in *The Daily Show* in New York in 2014 (see page 106). The truth was that I worked all day in my hotel room before I could go home the same evening, which the Show would not pay for, and my hospital had no problems with this. A third lie was that I "spent an extra day in Dubai." I did not spend any days in Dubai. I was three hours in transit in the middle of the night in the airport before I could take the plane to Australia.

One of the tricks Lund used was like asking: "Will it have consequences according to criminal law if Mr. Smith has strangled his wife? We have talked to a legal expert, and he confirmed that it will." The problem is that Smith *did not* strangle his wife.

Lund's articles attacked my research violently, citing disgruntled people with conflicts of interest, and claiming mendaciously that I had no documentation for my scientific messages in the media. Many people were convinced that Lund's smear campaign against me was ordered and paid for by the drug industry, perhaps to a bank account in some exotic tax heaven where people don't talk.

In his article about how powerful I was,[892] Lund referred to Cochrane leaders' denigration of my research on psychiatric drugs in 2014 but failed to note that they back-pedaled[893] (see page 314).

Sadly, the lies had an effect. Lies always have.

## Protecting the psychiatric guild while sacrificing the patients

As I have documented, leading psychiatrists lie monstrously about their specialty because it couldn't survive if they didn't. When reasonable people contradict their false narrative, they circle the wagons, cry "anti-psychiatry," and send poisonous arrows in all directions.

Journalists happily participate in the fool's paradise: "Gøtzsche, who has no special training in psychiatry, has become a fixture on the anti-psychiatry circuit."[894] Funnily, according to Wikipedia, anti-psychiatry is based on the view that psychiatric treatment is more often damaging than helpful to patients. Thus, most ordinary people are "antipsychiatry," as this is what they believe.[895] Bob Whitaker saw the article calling me anti-psychiatry and said that "The one thing that science reporters can't seem to understand is that psychiatry is a failed medical discipline, that indeed told a fraudulent story to the public."

It is no surprise that it is very difficult to get anything published in a psychiatric journal that the psychiatric guild perceives as threatening for their business. When Bob gave a talk in 2019 at the inaugural symposium for my Institute for Scientific Freedom about censorship, he presented two very important topics: *Do antidepressants worsen long-term outcomes?* and *What do we know about post-SSRI sexual dysfunction?*[896] None of 13 and 14 pivotal studies, respectively, about these subjects had been published in the top five psychiatric journals. It seemed that the top journals had never discussed these topics.

Bob has a list of important and large studies whose results were threatening to the psychiatric narrative and were not mentioned in any US newspapers.[897] When newspapers write about psychiatry, the story is usually misleading. The WHO did two studies showing that patients with schizophrenia fared much better in poor countries, where they couldn't afford to buy psychosis pills, but the public was not told that the pills are harmful.[898]

There are additional reasons why people with schizophrenia fared so well in poor countries.[899] The illness is often seen as the result of external forces, e.g. evil spirits, and people are much more likely to keep the sufferer in the family and to show kindness, with an expectation of full recovery, which helps patients recover and participate in social life again.

Psychiatry professor Giovanni Fava, who supported me at a meeting for psychiatrists in Denmark where we both lectured when I said that stopping SSRIs can cause withdrawal symptoms, which the psychiatrists flatly denied, found it so difficult to get results published that his peers didn't like, that he founded his own journal, *Psychotherapy and Psychosomatics*. Another Italian psychiatrist, Giovanni Fioriti, launched a free access journal with no author fee, *Clinical Neuropsychiatry*. He has published five of my books in Italian and invited me for dinner in his home.

The censorship in the media is also pervasive. They propagate uncritically virtually any falsehood psychiatry can think of. But when you submit a letter to a newspaper pointing this out, it will usually be rejected, even when you appeal the decision and explain that the facts you present are needed for a proper democratic and enlightened debate.

I have experienced this countless times. In October 2023, Allan Holmgren and I sent an article calling for radical changes including having coercion-free hospitals, to *Jyllands-Posten*.[900] It was accepted immediately, but despite many reminders, it wasn't published before we complained to the Editor-in-Chief who did not explain why it took six months to get it out. We are convinced some journalists didn't like our article and hoped it would go away if they postponed publication indefinitely.

In 2024, *Jyllands-Posten* praised the ADHD diagnosis and welcomed the fact that more and more adults got the diagnosis.[901] I pointed out gross errors in the article, e.g. the claim that children generally do not outgrow their diagnosis, but the editor refused to publish my letter claiming there were no errors. He asked me to contact one of the journalists who wrote the article on the phone, which I did. It was an awful experience. She did not understand anything of what I told her although I repeated my explanations. Many journalists are too dumb. You cannot reach them.

Later in 2024, politician Matilde Powers wrote an article in *Politiken* that was packed with falsehoods about ADHD. She claimed it was a biological disease like diabetes; that it was not overdiagnosed; that it explained what was wrong with people; and that ADHD drugs did not have serious side effects, increase the chance three times of having a job, reduce the risk of depression and suicide by 20%, increase the chance of completing one's education, and halve the risk of getting seriously injured in an accident or becoming a drug addict. As Allan and I were not allowed to rebut these lies in *Politiken*, not even after we had appealed, we did it on my website.[902]

After decades of disappointment about the way the media depict psychiatric issues, I finally had enough and wrote an article about why they constantly mislead us.[903]

Journalists often fail to seek out sources who can offer an independent perspective. And the idea of "balanced" reporting often leaves the public confused. The person offering a counter-point may be conflicted or dishonest,[904] but while journalists check if statements from politicians are true, they are uncritical towards what powerful people in healthcare say.

When robust research has shown that a drug is dangerous, and numerous poor studies have been produced by the doubt industry saying the opposite, journalists say that the researchers disagree. They have a huge responsibility in shaping public opinion, and they should do better than being the drug industry's useful idiots.

When the media - rarely - tell of a serious harm of a psychiatric drug, they feel they must also praise the drug. This results in meaningless and false marketing statements such as "despite their side effects, the drugs are worth taking."

Many journalists take psychiatric drugs, or they have friends or relatives who take drugs, work for a drug company, or are psychiatrists. I have experienced numerous vitriolic attacks on this basis. A journalist triumphed in a newspaper with the headline: *I take happy pills, otherwise I would be dead!*[905] She called me a life-threatening person, delusional, not in complete balance with myself, one who might need to see a psychiatrist, and I should be ashamed of myself and be deprived of my professor title: "My wish is that someone can stop the mad professor."

Criticism of psychiatric drugs rarely comes out, not even when the journalist is eager to publish it. Editors don't want to lose advertising income, and they often have financial conflicts of interest themselves. They also buy the false argument that any bad publicity about the drugs can cost lives and edit out the science in favour of personal anecdotes, which are more convincing for readers than hard-core science. Finally, they know that negative stories might lead to a storm of protests from key opinion leaders and questions might be raised in parliament, often via people secretly financed by the drug industry.

There can also be substantial pressures from patients, some of whom may be celebrities hosting TV programmes, and they may be readily offended if their illness is not recognised or if their drug use is questioned. Journalists will feel obliged to accommodate such people and to present their stories, and they can be afraid of being seen as uncompassionate.

I have given many examples of this media corruption, which is particularly bad when the media report on drug induced suicides.[906] I have often wondered why they never mention that psychotherapy halves the risk of suicide.[907] The obvious reason is that psychotherapists don't corrupt the media, the psychiatrists and the politicians with their money.

The bottom of journalism was reached when former First Lady, Rosalynn Carter, established the US Carter Center's Guide for Mental Health Journalism. It educates journalists to write flawed articles, uncritically repeating the misleading narratives created by the drug industry and psychiatrists, and to never question psychiatric diagnoses.[908] Some of the "facts" journalists are urged to include are that substance use disorders are diseases of the brain, and the guide explains that "Although science has not found a specific cause for many mental health conditions, a complex interplay of genetic, neurobiological, behavioral, and environmental factors often contribute to these conditions." This mumbo jumbo is misleading. We know that people's living conditions are more important than anything else.

It is difficult to see much hope for America. When the Carter Center tells journalists to ignore patients and listen only to psychiatrists, it is like telling journalists that if they want to know what it is like to live under the Chinese dictatorship, they should not ask the people but the Chinese leaders.

It is rare in healthcare that influential people do not have conflicts of interest, and in 2008, journalists Jeanne Lenzer and Shannon Brownlee published an article asking if there is an unbiased doctor in the house.[909] They noted that journalists often forget that conflicts of interest may bias the opinions of expert sources and gave the names of about 100 people, me included, whom they felt could be trusted and were not on the take. Their list was enthusiastically embraced by other reporters but was roundly condemned by colleagues who were paid allies of the drug industry - the industry apologists. There have also been attempts at smuggling moles onto the list under false pretences. A list of honest people is too much to bear for the drug industry.

When my book about Big Pharma's organised crime was published in Spanish in 2014, I was interviewed by a journalist from the leading newspaper in Barcelona, *La Vanguardia*. The interview was planned to fill the back page, which readers find more attractive than the front page. It never appeared, even though the journalist was very enthusiastic about it. I found out about financial relationships between the newspaper and the drug industry.

When my first psychiatry book came out in Swedish in 2016, I was interviewed by journalists from two major newspapers. They were highly interested, but nothing was published. Inger Atterstam from *Svenska Dagbladet* didn't reply to my emails asking why, whereas Amina Manzoor from *Dagens Nyheter* said her editor thought it would be too dangerous to tell people that depression pills are harmful and can cause suicide.

There was a crack in the Swedish censorship, however. A third newspaper, *Aftonbladet*, allowed me to publish an article that filled the whole back page where I explained that the drugs do more harm than good.[910]

The *Finnish Medical Journal* (*Suomen Lääkärilehti*) also exhibited censorship in 2016. I had published a paper on *Mad in America* about our systematic reviews that showed that depression pills increase the risk of suicide and violence at all ages; that psychotherapy decreases the suicide risk; and that the clinical benefit of depression pills is doubtful.[911] A Finnish translation of my paper was accepted, but a month later, the Editor-in-Chief, Pekka Nykänen, a business journalist, rejected it for no valid reason.[912] Nykänen violated the guidelines of the Committee on Publication Ethics that say that a decision can only be reversed if serious problems are identified.

I appealed to no avail, later also to the journal's owner, the Finnish Medical Association. I noted that editorial misconduct can be equally serious as scientific misconduct and should not be tolerated. I received a short mail from its CEO, Heikki Pälve, who did not address my complaints and the lack of response by Nykänen to my highly relevant questions. He replied that he respected "the editorial freedom of the journal." This was bullshit. It is not freedom to violate internationally accepted guidelines; it is editorial misconduct.

In 2017, Bob published a paper with the biblical title, *Thou shall not criticize our drugs*,[913] about a hugely flawed review that praised the long-term beneficial effects of neuroleptics although there are only harmful effects. Two groups of psychiatrists criticised the review in highly relevant letters they submitted to the journal, *American Journal of Psychiatry*, owned by the American Psychiatric Association, an organisation solidly corrupted by industry. The editor rejected both letters.

It can also be difficult to publish books about the horrors of psychiatry. Silje Marie Strandberg from Norway was bullied at school from age 12 and was admitted to a psychiatric ward when she was 16. She was diagnosed with moderate depression and was put on fluoxetine (Prozac). The dose was doubled after three weeks, which is insane, as it doesn't increase the effect, only the harms, including the risk of death.

Silje started cutting herself, became aggressive, heard an inner voice, and got suicidal thoughts. She was prescribed a psychosis pill, and three days later, she saw a man with a black robe and hood who said she was about to die and ordered her to drown herself in a river. She fought and cried when he spoke to her, said she didn't want to die, but he told her she didn't deserve to live. She went into the river while crying she wouldn't do it but thankfully came out again. These delusions stopped when she came off the drugs.

Psychiatry stole ten years of Silje's life, with serious self-harm and many suicide attempts. She was put in restraints 195 times, was diagnosed with schizoaffective disorder, got electroshocks and was secluded.

After seven years of torment, she met a caregiver who saw the girl behind the diagnosis and took care of her. This human effort is why Silje is alive and healthy today.

In 2016, Silje and her filmmaker, Inger Lene Stordrange, came to Copenhagen to film me for a documentary about her life.[914] The documentary is freely available. It is very good, informative and deeply moving.

Silje had an agreement with a book publisher, Psyk Opp, about what both of them perceived was one of psychiatry's success stories. I told her she had been seriously harmed by psychiatry, which she accepted, but when her psychiatric "career" was no longer a success story but a scandal, it was not possible to publish her book. She was not allowed to tell the world that the drugs she was on had made her terribly ill, to the brink of suicide.

Silje was medicated by 95 different doctors and received 21 different drugs during her psychiatric "career:" nine psychosis pills, five depression pills, four sedatives/hypnotics, two antiepileptics, and lithium.

Another story about censorship involved Danish Lundbeck that sells several pills against depression and psychosis. A very moving Norwegian film, *Cause of death: unknown*, had its world premiere at the Copenhagen documentary film festival, CPH:DOC, the largest in the world, in 2017.[915] It is about the filmmaker's sister who was killed by her psychiatrist. He overdosed her with olanzapine (Zyprexa) after first having turned her into a zombie. He was so shockingly ignorant that he didn't even know that olanzapine can cause sudden death.

I appear in the film and the filmmaker, Anniken Hoel, asked the organisers to put me on the discussion panel. My name was the only one in the announcement: *Medicine or manipulation? Film and debate about the psychiatric drug industry with Peter Gøtzsche*.

Seven days before the film was to be screened, I was kicked off the panel under the pretence that the organisers couldn't find a psychiatrist willing to debate with me. This was not the real reason. It turned out that the Lundbeck Foundation, whose objective is to support Lundbeck's business activities, had provided a major grant to the festival.

CPH:DOC never contacted me about it, even though I could have provided several names of psychiatrists willing to debate with me.

The panel included Nikolai Brun, newly employed at the Danish Drug Agency after a long career in the drug industry that ended just before the film festival, and psychiatrist Maj Vinberg whose benefactors included Lundbeck and AstraZeneca. She had published utter nonsense about depression being hereditary and observable on brain scans and was very fond of psychiatric drugs, which she seemed to know very little about (see page 130).

The panel debate was embarrassing. After 25 boring minutes, excepting the filmmaker's contributions, only five minutes remained. A former patient interrupted Brun, who had talked endlessly, shouting: "Questions!" Many people in the audience had lost loved ones, killed by psychiatric drugs, and they had become increasingly angry because the panellists only discussed amongst themselves and didn't want to involve the audience. There was time for only three questions.

A woman asked why neuroleptics had not been taken off the market, as they killed people. Brun replied he wasn't an expert on psychiatric drugs and embarked on another endless talk, about cancer drugs.

I then shouted: "Questions from the audience!" A young man said he had tried to come off his depression pills several times without success and without any help from doctors. Anders from my staff later helped him withdraw.

The last question was posed by Anahi Testa Pedersen whose film about me and her own experiences as a psychiatric patient had its world premiere in the same cinema seven months later.[916] She asked why I was taken off the panel since I could have made a good contribution and even appeared in the film. A festival spokesperson replied they had asked "a lot of people," but that no one wanted to debate with me. Anahi interrupted and named a psychiatrist who would have liked to come. The spokesperson changed tactics and now said that since the film was critical, there was no need for me; they needed someone to debate the film's messages. This was unadulterated bullshit.

In the middle of the endless fake excuses, someone in the audience shouted: "There is no debate!" The spokesperson replied that they would invite me for "tomorrow's debate," which I refused, as they had kicked me off from the world premiere of the film.

Seconds before the time ran out, I stood up and shouted (because I doubted, I would get the microphone): "I am actually here. I debate with psychiatrists all over the world, yet I am not allowed to do this in my hometown." There was a big laughter and applause, but the audience was angry. It was deeply insulting to them to show a film about a young woman killed by her psychiatrist without allowing any of those who had lost a family member in the same way to say anything. It was a brutal dismissal and a total prostration before the power of Lundbeck.

Anahi wrote about the scandal in a magazine for journalists.[917] She noted that before I was removed, the organisers had announced there would be a sharp focus on the overconsumption of psychiatric drugs and on whether drugs were the best treatment of psychiatric

disorders. After my removal, the focus was on the relationships between doctors, patients, and industry, which couldn't be a reason for removing me, as this was the subject of my award-winning book from 2013.[918]

CPH:DOC writes on its website: "We have many years of experience with sponsorship agreements that cater to both individual enterprises and to the festival. All collaborations are created in close dialogue with these individual businesses and are based on common visions, challenges and opportunities."

In response to Anahi's article, Vinberg wrote in the magazine it was a pity that a debate supposed to be about improving the future treatment of people suffering from a severe mental disorder ended in a rather indifferent debate about individuals (me). Her misleading statement was contradicted by her evasive responses during the panel debate.

It is very difficult to get critical documentaries on national TV. If you succeed, the best parts have been removed to avoid complaints from the psychiatric guild, the drug industry, or the Minister. I have appeared in many documentaries and have talked with many frustrated filmmakers about it. Even after they removed critical parts to suit producers, there were voiceovers saying, for example, that, "many people are being helped by antidepressants." If so, where are they?

When filmmaker Janus Bang wanted me to have a central role in his documentaries about how harmful psychiatry is, Janus needed to compromise extensively to get anything out on TV. Despite this, he broadcast three shocking programmes.[919] For example, he followed a young man who the psychiatrists came close to killing with their drugs. But the public debate he so much wanted to get major reforms introduced was totally absent. Psychiatry's firm grip on society prevented this from happening.

I wasn't allowed to appear unless a voiceover said that I am controversial. Janus refused, and I agreed. "Controversial" is a derogatory term that ensures the viewers will disregard everything you say, thinking you cannot be trusted. My opponents have often called me controversial while refusing to debate with me because they know they will lose. This primitivity is a kind of intellectual bankruptcy.

Drug exports are Denmark's biggest source of income, and in Janus's programmes, there were embarrassing, untruthful voiceovers paying lip service to Lundbeck and the psychiatrists, e.g. that drugs had revolutionised the treatment; that it may be necessary to use a potentially dangerous mixture of drugs to treat mental illness; and that there is no doubt that depression pills work.[920]

Journalists have told me that the reason Danish public TV doesn't dare challenge psychiatry or Lundbeck's commercial interests is due to the pushbacks around two programmes in April 2013. I was interviewed in one of them, *Denmark on pills*, by comedian and journalist Anders Stjernholm. The introduction to the programme mentioned a patient with massive side effects of depression drugs, another lost his sex drive, and a third was diagnosed with ADHD by a psychiatrist who never saw him.[921]

The overall message was that happy pills are dangerous and are prescribed too often. But the psychiatric empire hit back immediately. In an open letter to the TV station's board,[922] 92 specialists said they found it "deeply problematic that a public service channel felt it was its task to combat the use of a medication that is of crucial importance to the health of many people." They noted that the programmes were based on opinions from so-called experts, most often a specialist in internal medicine (me) who has "no experience with treatment of psychiatric patients … The broadcasts are a clear disavowal of the thousands of doctors who

treat patients with antidepressants on a daily basis who appear completely untrustworthy when, for decades now, they have been prescribing medicines which, according to DR's 'experts,' are ineffective at best, dangerous at worst."

In reply,[923] channel chief Michael Thouber noted that around 450,000 Danes use depression drugs; that the chairman for the general practitioners, Henrik Dibbern, had sounded the alarm about this "hideously high number;" that psychiatrist Poul Videbech had confirmed in a TV interview that rather few people had a depression requiring treatment; that the OECD had pointed out that Denmark was in a dismal second place in the use of such medication in Europe; that, at the end of 2012, both doctors, psychiatrists and the Minister of Health commented publicly that they found this alarming; and that some doctors are apparently too quick to prescribe the drugs without providing proper information about side effects and other forms of treatment.

Child and adolescent psychiatrists complained that the programmes could harm children with ADHD and noted that some parents had stopped treatment, which they claimed "can lead to a worsening of the symptoms and cause major problems with playing and socialising, participating in and benefiting from school education and causing risky behaviour."[924] I was called a populist professor even though what I had said was correct, in contrast to the false messages from over 100 psychiatrists about what their drugs can accomplish.

The depressing theatre continued. In a magazine for journalists, Videbech called the programmes a scare campaign that can cost people their lives and added that there had been suicides after friends and family advised the patient to drop their drugs.[925] He compared this with advising patients with diabetes to drop their insulin, even though he, at the same time, fiercely denied that he believed in the lie about the chemical imbalance (see page 124).

One reason why Videbech makes many errors, apart from his pronounced opportunism, is that he cannot interpret the science correctly.[926] He has claimed, for example, that citalopram can heal the destruction of brain tissue that depression causes,[927] with reference to a totally unreliable study where 32 depressed people got the drug for 8 weeks.[928]

Videbech was angry that he had been left out of the programmes and complained on Facebook and to TV. He felt the journalist had repeatedly asked him questions according to his own agenda, which was that "antidepressants do not work;" "if they work, they cause suicide;" and "when you stop them, they cause horrible abstinence symptoms." I had documented for Stjernholm that the pills don't work; that they increase the risk of suicide; and that patients can get horrible withdrawal symptoms when they try to stop them.

Videbech is often interviewed and uses his oracle status to influence the public agenda, to shape people's beliefs, and to attack people who disagree with him maliciously. When I once told my colleagues that Videbech and I had debated depression at the annual meeting of the Danish regions and that it went well, without undue attacks from Videbech, a psychiatrist remarked that if I wanted to keep a pet, I should not choose a poisonous snake.

People are not so dumb as Videbech thinks. There were many wise comments on his magazine article. One noted that I was correct that the media are uncritical and that many people had tried to warn against psychiatric drugs but had been silenced or fired.

Another found it incredibly manipulative that Videbech claimed that people had committed suicide after stopping their drug and had compared this with diabetics needing insulin.

One noted that there were virtually no tapering programmes in psychiatry and that it was solely up to the doctor's opinion what to do, which resulted in lifelong medication for many people.

One mentioned she was a member of a large support group helping people harmed by psychiatric drugs, and that every time they tried to open a debate on this topic, they were accused of not thinking about those who benefit from the medicines and were told that their information could have fatal consequences.

One wondered why we heard nothing from psychiatry about the suicides and suicide attempts that the drugs cause: "Because it gets dismissed as non-occurring. Nevertheless, it was on the list of side effects in the package insert of the medication I received. AND I felt the impulse on my own body. BUT I was told it was my depression that was the trigger for suicidal thoughts and plans. The strange thing about that was that the impulse came shortly after I started on the drug ... But the conclusion from the doctor and others involved was that my dose should be increased, which I luckily declined and decided to taper off the drug on my own. That people change their personality totally - become aggressive and hot-headed, paranoid, etc. - is also dismissed."

Only four days after Stjernholm's documentaries, journalist Poul Erik Heilbuth showed a fabulous documentary, *The dark shadow of the pill* on TV.[929] He showed how Eli Lilly, Pfizer and GlaxoSmithKline concealed that their depression pills cause some people to kill themselves or others, or cause completely normal and peaceful people to suddenly start a spree of violent robberies in shops and gas stations they were unable to explain afterwards and were mystified about. The pills changed their personality totally. Heilbuth told the stories of several people who had killed themselves or others.

The background material (no longer available) noted that Professor Tim Kendall - the head of the government body that advises all English doctors - called the theory of the chemical imbalance rubbish and nonsense. Professor Bruno Müller-Oerlinghausen - the leader of the German doctors' Medicines Commission for 10 years - called the theory insane. Both professors said the theory was a pure marketing strategy for drug companies. Heilbuth furthermore noted that the official Danish health website (sundhed.dk, partly written by Danish professors of psychiatry) propagated the chemical imbalance nonsense.

Heilbuth had whistleblower Blair Hamrick in his film, a US salesman who said that their marketing mantra to sell GlaxoSmithKline's drug paroxetine (Paxil or Seroxat) was that it is the happy, horny and skinny drug. They told doctors it will make you happier, you will lose weight, it will make you stop smoking, it will increase your libido (it does the opposite) - and that everybody should be on this drug.

The reactions to one of the most truthful films about psychiatric drugs ever produced were fierce. An editorial in the newspaper *Politiken* condemned the documentary in a very hostile fashion, and Heilbuth responded.[930] *Politiken* called his film "immensely manipulative," "sensationalism," "merely seeking to confirm or verify the thesis that the programme had devised as its premise," and they called Müller-Oerlinghausen a "muddled thinker."

It looked as if *Politiken*'s editorial was written by Lundbeck. The "muddled thinker" lectured all over the world, including at a symposium a little earlier organised by the Danish University Antidepressant Group. He was very clear and well-argued, and what he said was absolutely correct. David Healy was also one of the film's main sources.

In 2016, Videbech attacked TV again, in his usual arrogant fashion, after its documentary, *The healthy patients*. He accused the programme of stigmatising people with depression and not doing proper journalistic research,[931] which wasn't correct and was rejected by the programme director.[932]

**Ten myths in psychiatry that are harmful for the patients**

In January 2014, I published the article, *Psychiatry gone astray*, in *Politiken*[933] and also in English.[934] I described ten myths in psychiatry that are harmful for the patients:

Myth 1: Your disease is caused by a chemical imbalance in the brain.
Myth 2: It's no problem to stop treatment with antidepressants.
Myth 3: Psychotropic drugs for mental illness are like insulin for diabetes.
Myth 4: Psychotropic drugs reduce the number of chronically ill patients.
Myth 5: Happy pills do not cause suicide in children and adolescents.
Myth 6: Happy pills have no side effects.
Myth 7: Happy pills are not addictive.
Myth 8: The prevalence of depression has increased a lot.
Myth 9: The main problem is not overtreatment, but undertreatment.
Myth 10: Antipsychotics prevent brain damage.

I ended my article this way:

"Psychiatric drugs can be useful sometimes for some patients, especially in short-term treatment, in acute situations. But my studies in this area lead me to a very uncomfortable conclusion: Our citizens would be far better off if we removed all the psychotropic drugs from the market, as doctors are unable to handle them. It is inescapable that their availability creates more harm than good. Psychiatrists should therefore do everything they can to treat as little as possible, in as short time as possible, or not at all, with psychotropic drugs."

My article caused an outcry, spearheaded by the drug industry and their paid allies among doctors and the media. But it also led to the biggest debate in Denmark ever about psychiatric drugs. For more than a month, there wasn't a single day without discussion of these issues on radio, TV, in newspapers, and at psychiatric departments.

This surprised me. Half a year earlier, I wrote something similar in my book about organised crime in the drug industry, in the chapter, *Pushing children into suicide with happy pills*. I wrote the exact same sentence about citizens being far better off if we removed all psychotropic drugs from the market but this did not result in a prolonged debate about the drugs.[935] I also wrote: "How come we have allowed drug companies to lie so much, commit habitual crime and kill hundreds of thousands of patients, and yet we do nothing? Why don't we put those responsible in jail? Why are many people still against allowing citizens to get access to all the raw data from all clinical trials and why are they against scrapping the whole system and only allow publicly employed academics to test drugs in patients, independently of the drug industry?"

This time, I got the whole Danish establishment on my back, including the Danish Cancer Society, the Danish Medical Societies, the Danish Patients Association which opined that I derailed the debate,[936] and the director of the Board of Health, Else Smith,[937] who, however, thanked me the same day on the radio for having raised an important debate.[938] Thomas Middelboe, chairman of the Danish Psychiatric Association, lied bluntly on *Politiken's* website saying that depression drugs protect against suicide.[939] The Minister of Health, Astrid Krag, called my article vulgar, stupid and dangerous[940] and declared that my person and the centre wasn't the same thing,[941] which we interpreted as meaning that I could be fired. Very weird, as I had simply pointed out what was well documented and what many others had

pointed out before me,[942] but this is not tolerated when the subject is psychiatry. Shooting the messenger is much easier than changing a sick system.

Jesper Tabias Andreasen, PhD in psychopharmacology, wrote that I was anti-psychiatry and scared the patients away from taking their drugs. His headline was satirical: *We could remove all drugs (not only psychiatric drugs) and avoid all side effects*.[943] Like Andreasen, the press also misrepresented what I had written so that I needed to state that I had never argued that all psychiatric drugs should be removed from the market.[944]

Henrik Dibbern, chair of the Association of General Practitioners, supported me: "Peter is not a great diplomat. But it is also necessary to shout loudly in this area. Even when he provided heavy documentation, he was often ignored."[945]

Kristian Villesen, editor of the newspaper *Information*, was one of the very few journalists who understood the issues.[946] He wrote that I had provoked general practitioners and psychiatrists so much that they deliberately failed to read the text properly, which is why I was "exhibited as an advocate that no one should be given psychotropic drugs. No sane person thinks that - not even Gøtzsche. His sharp rhetoric was obviously an attempt to provoke the doctors to think about how much medicine they prescribe. The point was that the doctors should get better - not that the medicine should be taken off the market. People with a specialist medical training behind them should be able to see through this - and of course they can."

Editor of *Politiken*, Christoffer Emil Bruun, also saw through all the smoke and mirrors.[947] Under the headline, *Is there a normal Dane present?*, he wrote that the explosion in drug usage, which the Minister of Health, Astrid Krag, had said called on the attention of Parliament in *Politiken* in 2012, did not get the attention of the whole country before I wrote about it. He criticised the psychiatrists for not having addressed what I wrote about, e.g. the influence of the drug industry and that the diagnoses are not reliable. Instead, the psychiatrists had claimed that more patients need depression drugs that are not on them than patients who are on them that don't need them.

In his newsletter to the Danish Psychiatric Association, Middelboe repeated the falsehood that I wanted to take all the psychiatric drugs off the market, which he said was life-threatening.[948] The absolute low point was delivered by Kessing, Nordentoft and Middelboe who, on behalf of all professors in psychiatry and in child and adolescent psychiatry, and the Danish Psychiatric Association, declared - without mentioning my name, just like one was not supposed to mention the evil Lord Voldemort's name in Harry Potter - that:[949]

- there is no overtreatment of depression
- antidepressants work and prevent new episodes
- antidepressants reduce the risk of suicide in children
- antidepressants do not lead to dependence
- antipsychotics work and reduce the risk of death
- Open Dialogue does not work (for psychoses)
- exercise has no effect on psychiatric disorders.

Middelboe said they wrote the article because there are so many myths and erroneous information about psychiatric drugs in Denmark. Which they then propagated themselves, as *all* their claims are wrong. They didn't see the irony when they called me extreme and unreliable.

I told *Politiken* that I needed to write another article because of their many errors and falsehoods, and I published, *Leading psychiatrists have still gone astray*.[950]

An editorial in an industry funded magazine said that "It is not possible not to admire the courage, Peter Gøtzsche displays. The Cochrane boss is as popular in healthcare as Voldemort is in Harry Potter."[951] My opponents often used my name in the titles of their articles, which is a kind of harassment, and it also happened this time. The magazine published a 7-page article, *Peter, the wolf: Gøtzsche versus Gøtzsche,* which was an attempt at character assassination.[952] Two full pages were a photo of one of my eyes:

Child and adolescent psychiatrist Lisbeth Kortegaard provided a devastating criticism of the article.[953] She called it mean and spin of the worst kind to compare me with a predator and noted that she had observed how I was celebrated at the Selling Sickness meeting in Washington DC in 2013 and the Preventing Overdiagnosis meeting in Dartmouth, also in 2013.

Two months later, Lisbeth wondered why the psychiatrists continued their witch-hunt after me, noting that they should think about why one of every 500 Danes considered my article important.[954]

One month after my article in *Politiken*, 16 Danish professors of psychiatry responded to it.[955] Among other things, they repeated the gigantic lie that treatment with neuroleptics increases longevity, compared with no treatment.

Outside the power circles, my paper about the ten myths was much appreciated.[956] It was translated into English, Spanish, Norwegian and Finnish, and many articles followed, some written by psychiatrists who agreed with me. People in Norway and Sweden thanked me for having started a debate that was impossible to have in their country, and I received hundreds of emails from patients who confirmed with their own stories that what I had written was true.

One patient wrote that he was admitted with a first-episode mania, and although he asked not to be treated with drugs, he was forced to take olanzapine, a psychosis pill. He tried to behave well, fearing that he might otherwise not be released. At discharge, a psychiatrist declared him cured and insisted that he should continue with the drug. He didn't dare tell her that he had spat out most of the pills in the washbasin but asked, for the sake of appearances, for how long he should take the drug. For the rest of your life, she replied, because he had a chronic disease, with a great risk of relapse, and he should not be afraid of the drugs' harms. The reason why he didn't take the drug was that he had read my article. He has been well ever since without drugs.

Psychiatry continued as usual, but many people told me that my books and articles had saved lives. They gave the patients the courage to stop their drugs against their doctor's advice. Ten months after my article, *BMJ* published a paper with views very similar to mine,[957] but the authors did not become scapegoats for psychiatry's failure to deliver.

**Deadly psychiatry and organised denial, my first psychiatry book**

My first psychiatry book appeared on 31 August 2015.[958] There were two articles in *Politiken*,[959] and I was interviewed by both Danish TV stations. Two weeks later, it was the second most sold non-fiction book in Denmark.

It was good PR for Cochrane, which I mention 131 times in the book, and there are 35 references to Cochrane reviews.

The book has appeared in nine languages and was praised by critical psychiatrists, doctors from other specialties, psychologists, other people from the caring professions, lay people, patients, and journalists.[960]


When I was interviewed for a science site, they included a drawing my 10-year-old daughter Pernille had made where Pippi Longstocking carried a horse. The idea was that, when she could to that, I could also change science, which was the title of the article.[961]

Readers of the newspaper *Berlingske* nominated me for "Dane of the Year" in 2015 where I ended in top ten. At the award ceremony, I met with the Prime Minister, Lars Løkke Rasmussen, who said he appreciated my work with drugs. Eske Willerslev, our world-famous DNA researcher, who has unravelled many historic migrations of people including that the American Indians came from Siberia and that the Danes came from Caucasus, also appreciated my work. He offered to give a lecture at my centre, which he subsequently did.

Under the headline, *I call a spade a spade*, a journalist explained why I had been nominated:[962] "In particular, he has drawn attention to the harmful treatment methods of psychiatry with his book 'Deadly psychiatry and organised denial.' He has thus made a very significant contribution to public education and to a debate, which has been much needed ... Professor Peter C. Gøtzsche is fighting a tireless fight for medicines to be used correctly ... Like no one else, he has started a vital debate about overmedication."

My work for the patients was so much appreciated that I became winner of the Annual Award for the National Association for Psychiatry Users in Denmark in 2014 and Protector of the Danish Hearing Voices Network in 2016.

In 2020, I got an award from the Patient Association Denmark, for being the decade's most brave doctor in Denmark. Journalists are less brave. The day I received the award, the TV programme *Good Evening, Denmark* cancelled a feature where I should have spoken about my new book on vaccines. The excuse was that they were not really dressed for the task, but journalists are rarely dressed for the task, no matter what the subject is.

A patient wrote an article about my book aptly called, *Psychiatry: Doctors without borders*.[963] Another person wrote that I would go down in history for daring to show that the emperor was naked, and that, in the best of all worlds, a book like mine would lead to big and comprehensive changes. Yet another hoped for a more humane care with less dogmatic medicine but doubted it would happen.[964]

Psychologist Svend Brinkmann noted that if I was correct, psychiatry needed to be radically changed, without delay.[965]

Doctor of biology Iver Mysterud wrote that my book is probably the most important one that is critical of psychiatry.[966] He liked my direct style and noted that if we want to revolutionise psychiatry, we cannot treat people with verbal silk gloves. He also said that when traditional psychiatrists had tried to dismiss my criticism as erroneous, I had crushed their arguments through incisive analyses.

Psychologist Hans Peder From wrote that one of his clients was so medicated that she slept all the time, was unable to take care of her child, and just wanted to get a disability pension.[967] He convinced her to taper off her medication and she became a competent mother with a full-time job.

His wife was also overmedicated and couldn't do anything. It was difficult for him to persuade her to come off the drugs because her psychiatrist was very much against it. When his wife asked for some literature on recovery, it turned out that the psychiatrist had never heard of this concept. And when they inquired if it would make sense to try to get a new psychiatrist, they were told that she was the most modern and progressive of the staff.

The tapering was extremely hard, with violent nightmares, and Hans had recurring discussions with his wife. Was the psychiatrist right that she would always be sick? Or was he right that she could do much better?

His wife can still become psychotic in stressful or emotionally charged situations, but this was also the case when she was drugged, and she is doing much better now. As he says, in biological psychiatry, there is no ambition to make people healthy. They aim for well-medicated and well-regulated patients, which is just a nice way of saying you've created another chronic patient.

A client told him about her brother whose psychiatrist had said he was schizophrenic and needed to take medicine for the rest of his life. This was the last conversation she had with her brother before he killed himself. People with mental illness can fully or partially recover, but not when the treatment system robs them of all hope.

My book was forcefully attacked by the establishment. Allan Flyvbjerg, Dean at Aarhus University, said it is downright harmful for psychiatric patients when a high-profile researcher like me comes up with "biased and rigid attacks on drug usage in psychiatry."[968] In his view, the road to a better psychiatry was clear: New and more targeted psychiatric drugs, and he praised the Lundbeck Foundation for a big grant exceeding 240 million crowns.

I replied that since Flyvbjerg was an endocrinologist, he should have been concerned that many patients treated with neuroleptics become obese and develop diabetes and cardiovascular diseases.[969]

Top psychiatrists denigrated my book and – as always – they lied about what I had written. Torsten Bjørn Jacobsen, chairman of the Danish Psychiatric Association, published a pathetic and untruthful review in our medical journal.[970] He claimed that I believed that suicide and psychoses would not occur if it were not for the abuse in psychiatry; said I had no expertise in psychiatry and quoted selectively; and found my style implacable.[971]

Well, if you want to achieve changes in psychiatry, you need to be clear about what you say. And not being a psychiatrist (the "you are not one of us" argument) is immaterial. You don't need to be a banker to have a qualified opinion about the 2009 financial crisis. And when I document how ineffective and harmful psychiatric treatments are, I use research done by psychiatrists and supplement it with my own research.

True to himself, Poul Videbech was evil. He was behind this headline in *Politiken*: *I have had patients hospitalised who stopped taking medication and attempted suicide because of the debate that was going on*.[972] He called it unethical not to treat severe depression with depression drugs arguing that it increases the risk of suicide not to treat and the risk that the depression becomes chronic and impossible to cure. The truth is the opposite,[973] but leading psychiatrists are so used to lying that they don't even notice when they lie.

Raben Rosenberg called it an unethical, monomaniac, anti-psychiatry crusade against psychiatric patients and opined that I was unable to interpret the scientific literature.[974]

Pernille Lundqvist claimed on Facebook that my articles and books were devoid of evidence, which she opined was why the debates were derailed.

In an article called, *Peter Gøtzsche as today's crusader*, Mads A Meldgaard Madsen claimed that drugs are an absolute prerequisite for conversations, care, professional help and recovery, in direct contrast to the evidence.[975]

Psychiatrist Henrik Day Poulsen claimed I was the leader of an anti-psychiatry movement and that drugs prevent suicide and violence and increase the quality of life substantially. He found it dangerous to have an academic discussion and ignore clinical experience![976]

John Hagel Mikkelsen claimed I was totally ignorant about psychiatric disorders and their treatment and that his 25-year clinical experience told him that seriously ill patients with psychosis or depression come back to life with the help of antipsychotics or antidepressants.[977]

A Finnish psychiatrist called his book review *Anti-psychiatry 2.0* in the *Finnish Medical Journal.*[978]

Swedish psychiatry professor Mikael Landén wrote an extremely mendacious book review in the Swedish medical journal: *Gøtzsche's book is the opposite of scientific honesty*.[979] Landén's claims are free fantasy, and the reader comments to his review are interesting.[980] I have never said that:

- psychiatric drugs have no positive effects at all
- they "regularly" drive people to murder and suicide
- it is doubtful whether mental illness exists
- voice hallucinations are normal
- if only the patients were freed from the psychiatric web, mental illness would disappear
- it is a myth that Alzheimer's is a brain disease

Landén's lies were brutal: "His only explanation for the fact that psychiatric drugs have been shown to have effects in studies, and are used, is corruption and conspiracies." It is also a lie that I do not provide references when I conclude that some psychiatrists are corrupt. I give

many references and mention names, for example Anders Forsman from Sweden and Joseph Biederman from the USA, with references to the corruption.

Landén claimed that I did not document that about half of the psychiatrists lie to their patients. But I write on page 8 in the book: "One sign that psychiatry is in deep crisis is that more than half the patients believe their mental disorder is caused by a chemical imbalance in the brain. They have this misperception from their doctors, which means that more than half the psychiatrists lie to their patients."

Landén claimed that I do not have compassion for those who suffer from mental illness and that as an anti-psychiatric knight I am not interested in the suffering and disability that mental illness leads to in everyday life for many fellow human beings. He was happy to discuss, but only with "people who have at least rudimentary knowledge of psychiatry and some small compassion for those affected."

Landén said he learned nothing from reading my book. This is impossible.

Several psychiatrists felt Landén had written an excellent book review and agreed that I was anti-psychiatry, whereas child and adolescent psychiatrist Sven Román wrote that if only a fraction of what I had written was correct, psychiatry was a gigantic scandal.

These were defining moments when Swedish and Danish psychiatry revealed the extent to which they are willing to lie about the facts to the public to protect their guild.

A few psychiatrists did not delude themselves and the public. Jens R Bang noted that his colleagues had not been able to counter my arguments with reference to concrete research and he called for an academic debate: *Evidence-based psychiatric treatment, what else?*[981]

Frits Schjøtt wrote that my book was not encouraging reading, but if we hoped to wrest the poor people with psychological problems out of biological psychiatry and the mafia claws of the pharmaceutical industry, there was no other way.[982] He wished he had known what my book had taught him 40 years ago, which would have been good for his patients and for his self-esteem in his retirement, but “we needed an independent researcher in the new millennium to open our eyes.”

Stuart Shipko from California wrote on *Mad in America*[983] that my book “brings up an important and complex issue. How do psychiatrists get up in the morning and damage people all day long while pretending to help them? The book is elegantly referenced - and I encourage everyone who practices thoughtful psychiatry to read it, because you need to be much better educated to practice high-quality mental health than you do to act as a dispensing machine. Gøtzsche is absolutely right; on all levels psychiatrists are in denial about the damage that they are doing to patients ... Even taking cognitive dissonance into consideration, psychiatrists can surely see what is in front of their eyes. I remember years ago when Risperdal - the new miracle antipsychotic - came on the market. The first patient I gave it to gained about 60 pounds in just six weeks ... I have never prescribed Ritalin or other stimulants for children … How can a doctor fail to notice stunted growth that makes a 12-year-old look like a 9-year-old? How can a doctor fail to notice all the tics and twitches? … Patients complained all the time about sexual dysfunction continuing long after stopping SSRIs. Pharmacists know about this problem. Patients are well aware of this problem. I recall an attorney who was having mild depression related to financial difficulties. He was given samples of Paxil for a month or two, until I ran out of samples. He was unable to afford the prescription. Three days later he attempted suicide. One patient of mine in therapy for panic attacks with no depression was convinced by her daughter to get an SSRI from her family doctor. She hung herself from a stairway in her house a few days later ... When I see patients

for second opinions about what is usually an unnecessary cocktail of drugs for a diagnosis of bipolar disorder, despite the fact that the patient never had a manic or hypomanic episode, I often ask a Socratic question. I ask them to visualize their psychopharmacologist, and ask themselves whether they would buy a used car from this person. Most patients laugh - and say that they would not. So why trust your life to this person?"

When my book had been translated into Spanish, my publisher, Enrique Murillo, arranged a meeting at a bookshop in Barcelona in September 2016 where I would lecture followed by discussion. There was a little panel of honoratiores (dignitaries) that were asked to introduce themselves. They talked at length about how splendid they were. I got increasingly annoyed and nervous, and after a long while I raised from my chair and wandered around a little to show my impatience, which didn't affect them. When they finally stopped talking, I said there wasn't time for my lecture and asked if there were any questions. I was then told to give my lecture, which I couldn't, so I just uttered a few sentences.

I had come all the way from Denmark to give a talk in Barcelona and another one in Madrid, but these people were only interesting in displaying their feathers. It was intensely frustrating, by far the most horrible (non)lecture in my whole life.

**Biological psychiatry: a total betrayal of public trust**

The prevailing biological model of mental disorders assumes they are brain diseases caused by specific biological abnormalities that can be fixed by drugs.

In their desperate attempts at defending what cannot be defended, leading psychiatrists have published a lot of harmful nonsense, in direct contradiction of the most reliable science we have. I have provided numerous examples of this in my articles and books, including in the most recent one.[984]

Examples of false claims are: Psychiatric drugs have transformed the lives of millions of psychiatric patients for the better and reduced stigma;[985] they prevent relapses and it is a myth largely fuelled by the media that depression drugs increase suicides;[986] neuroleptics increase survival;[987] and psychiatric drugs decrease the risk of crimes.[988]

Textbook authors are preoccupied with telling the students that psychiatric disorders are hereditary, which gives the specialty prestige. It makes it look more scientific to claim that the disorders are in the genes and can be seen in a brain scan or in brain chemistry. There is a lot of detail about genetic research in the textbooks but none of it is correct.[989] The many twin studies have been debunked, but even if true, it would have no consequences, as we cannot change our genes.

Misconceptions in healthcare often live on for as long as those who propagate them are alive, which means decades. Even today, official websites claim that the risk is 10-15% that children will become schizophrenic if one of the parents have schizophrenia,[990] and the misinformation can be much worse. A 2022 article in *Nature* mentioned that "Schizophrenia has a heritability of 60-80%, much of which is attributable to common risk alleles."[991] Yet, in another article by the same research group, which is very difficult to comprehend, the genes appeared to explain only about 2% of the risk that a person will be diagnosed with schizophrenia![992] Thus, 98% of the risk must be because of something else, most notably trauma, where there is a clear dose-response relationship.[993]

When molecular genetics has consistently failed to produce anything about diagnoses being related to specific genes, we are told that the area is "complex."[994] This is bullshit.

Yet, many billions of dollars have been wasted by the NIMH on finding genes predisposing to psychiatric diseases and on finding their biological causes. And even though the many gene studies have not come up with anything,[995] the mad hunt for the Loch Ness monster continues.[996] Whenever I examined claims that psychiatric disorders are caused by brain abnormalities, I found that the research was unreliable.[997]

It is harmful to tell the patients that their disorder is hereditary, as it takes away their hope of becoming healthy again. If instead the psychiatrists focused on the environment the patients live in and the traumas they have experienced, there would be hope of recovery, as the environment can be changed, and traumas can be treated with psychotherapy.

In contrast to the psychiatric leaders, the public is convinced that madness is caused more by bad things happening than by genetics or chemical imbalances in the brain.[998]

The textbooks protected the psychiatrists' guild interests and the interests of the drug industry by not mentioning that most of the drugs they use can cause the disorders they try to treat, other disorders, or deadly harms. They did not comment on the well-known studies showing that psychosis pills shrink the brain in a dose-related fashion and that the disease cannot explain these changes.[999] Some authors claimed that untreated psychosis increases the loss of brain volume; that it is likely that psychosis pills can offer some protection; and that prolonged untreated depression may cause brain atrophy. There is no reliable research in support of these wild fantasies.

Strangely, ADHD - one of the most controversial diagnoses in medicine - was claimed to be one of the psychiatric disorders with the strongest evidence for a neurobiological etiology, with aberrations on brain scans (which isn't correct, see page 154). Even anxiety disorders were claimed to be visible on brain scans, which normalised on successful treatment. This is a tautology like: It will rain tomorrow, or it will not rain. If the brain scan was not normalised, the treatment was not effective.

Child and adolescent psychiatrist Sami Timimi explains in his book *Insane medicine* that psychiatry ignores much of the genuine science and instead supports and perpetuates concepts and treatments that have little scientific support.[1000] He calls this scientism. Psychiatry likes to talk in the language of science and treats this as more important than the actual science, which is what practitioners of alternative medicine also do.

Humans do not like uncertainty, which is in our genes, as indecision decreases our chance of survival. It is a curious trait of human psychology that once you have made up your mind, even when you were in serious doubt, you will vigorously defend your position when someone proves that the other option was correct.[1001] People may therefore spread their false ideas more forcefully when confronted with irrefutable evidence that they are wrong. Psychiatrists also need to defend the way they practice. As Upton Sinclair said, "It is difficult to get a man to understand something, when his salary depends on his not understanding it."

I wrote *Critical Psychiatry Textbook*[1002] hoping I might influence the students before it is too late, and they have accepted the false narrative. I have told students[1003] that if they ask questions to their teachers based on my book, they might be fobbed off with replies like, "Gøtzsche? Never heard of him" (even though they know who I am) and "Is he a psychiatrist? Has he ever managed psychiatric patients? How can he judge what we do?" Or they will say I am anti-psychiatry, which is silly. We have never heard of an anti-cardiologist, and you are not an anti-mechanic because you criticise poor repair work on your car.

The many false and misleading statements I found in the textbooks cannot be explained by the advent of new, important knowledge, as the publication dates for the textbooks are recent, from 2016 to 2021, and as progress in psychiatry is very slow or non-existent.

The textbook authors were heavily influenced by the drug industry. They never spoke of harms of drugs, only "side effects," which is a euphemism. All the books used industry jargon and talked about first-, second-, and even third-generation pills; some neuroleptics were called atypicals and some were called modern, suggesting you are outlandish if you prefer older drugs. As the drugs *within* these arbitrary classes are widely different in their effects, it is meaningless to divide them this way.

There wasn't a single remark in the textbooks that off-patent drugs should be preferred because they are vastly cheaper and not any worse than patented drugs. It was as if health economics is something you can only find on the Moon or in excavations.

The psychiatric leaders have given up rational thinking for the benefits they acquire from supporting a sick system. The best example of psychiatry's total betrayal of public trust is provided by the director of the NIMH from 2002 to 2015, Thomas Insel, who was called "America's psychiatrist." In 2022, he published a book where he takes on the role of a drug salesman, selling the wonders of psychiatric drugs to the public, but his dishonesty starts already with the title, *Healing: our path from mental illness to mental health*.[1004]

Psychiatric drugs cannot heal mental disorders, and the path the psychiatrists have taken is not from mental illness to mental health, but from bad to worse. If you read the book with open eyes and see through all the window dressing, you'll see that it makes an unintended case for abolishing psychiatry even though Insel tries to support it.

As the NIMH is the most prestigious institution in the world in mental health, Bob Whitaker took a close look at the book,[1005] which I have summarised.[1006] Being a former NIMH director, Insel had an ethical obligation to tell his readers about the poor long-term outcomes of drug treatment, as documented in expensive and prestigious research funded by the NIMH. He didn't, even though the NIMH was the only institution in the world that funded big, long-term drug trials.

The largest effectiveness study ever conducted of depression pills is the STAR*D study of 4,041 "real-world patients." It is a gigantic $35 million fraud financed by the NIMH at a cost of $35 million.[1007] The NIMH claimed a success rate of about 70%, but there was no control group and only 3% of the patients who entered the study remitted, stayed well, and stayed in the trial during the one-year follow-up.

Bob provided a highly revealing summary of studies Insel didn't dare mention. As Bob noted, the science shows that pills for psychosis and depression increase the chronicity of the disorders, and this is also the cases for stimulants, benzodiazepines, and drugs used for bipolar disorder. There is a list of over 100 papers that tell of these harmful outcomes on the *Mad in America* resource pages.

Insel could have remedied 70 years of betrayal of public trust with his book and put psychiatry on a new path, but as psychiatric leaders always do, he sacrificed the patients and protected the psychiatric guild by keeping the long-term studies financed by his own institute hidden. Insel wrote that the number of adults in the USA receiving a social security payment due to a mental disorder rose from around 1.3 million in 1987 to around 6 million today. This is not a "path from mental illness to mental health."

Five years after Bob's second book came out, Insel told a filmmaker that Bob's observations needed to be taken very seriously and noted that, in other areas of medicine, if you increase the use of your medication several times, you will see reductions in morbidity and mortality.[1008] This short glimpse of sanity and self-insight quickly disappeared, and Insel is both evil and mendacious. In his book, he claims that Bob writes that the psychiatric estab-

lishment, in collaboration with the pharmaceutical industry, has conspired to overmedicate and overtreat children and adults with disastrous results, and that not everyone buys this conspiracy theory. The only time Bob used the term conspiracy in his book was when he quoted a patient with schizophrenia who spoke about conspiracies!

Insel claims that drugs, ECT, and transcranial magnetic stimulation work and that depression pills have an effect size that is often higher than medications used in other areas of medicine. A remarkable statement about drugs that have no clinically relevant effects. My view on this type of argument is that one unlawful parking doesn't make the next unlawful parking lawful. There are many ineffective drugs that shouldn't be used.

Insel's book is a superb example of manipulation. The emperor is naked but so well dressed up that few readers will notice it.

Psychologist Bruce Levine wrote in 2024 that "exuberant individuals who disregard societal consensus reality are routinely diagnosed by psychiatrists with bipolar disorder; however, among psychiatrists themselves, exuberance about psychiatry regardless of the reality of psychiatry's repeated scientific failures makes one a leading psychiatrist."[1009]

Bruce says that, in the 21st century, there has been no higher-level psychiatrist than Thomas Insel who is a prime example of an exuberant psychiatrist. He pushed neuroscience and genetics and got papers published at a cost of about $20 billion, and even though this did not result in anything useful for the patients, he has no regrets about NIMH funding all this. Moreover, Insel wrote in his book that "The idea of mental illness as a 'chemical imbalance' has now given way to mental illnesses as 'connectional' or brain circuit disorders." This is plain nonsense, with no supporting evidence, that attempts to resurrect the stone dead lie about the chemical imbalance by calling it something else.

Insel's book is a gravestone for psychiatry and his own contribution to it. It is a work of propaganda for a sick system, praising harmful treatments as if they were beneficial.

## Psychiatrists seem to be more mad than their patients

When I discuss psychiatry with critical psychiatrists, psychologists or pharmacists I collaborate with, we sometimes wonder who are most mad, the psychiatrists or their patients?

This is not a joke or a rhetorical question. An Oxford dictionary defines delusion as "An idiosyncratic belief or impression maintained despite being contradicted by reality or rational argument, typically as a symptom of mental disorder."

The WHO's International Classification of Diseases (ICD) has this definition: "A belief that is demonstrably untrue or not shared by others, usually based on incorrect inference about external reality. The belief is firmly held with conviction and is not, or is only briefly, susceptible to modification by experience or evidence that contradicts it."

The DSM-5 defines delusions as "fixed beliefs that are not amenable to change in light of conflicting evidence. Their content may include a variety of themes (e.g. persecutory, referential, somatic, religious, grandiose) … Delusions are deemed bizarre if they are clearly implausible and not understandable to same-culture peers and do not derive from ordinary life experiences."[1010] Common types of delusions are:

Persecutory: People believe they are at risk of being harmed because of the malevolent intentions of others.

Reference: People believe that innocuous events, e.g. the gestures of strangers or radio news bulletins, are being deliberately targeted at them.

Grandiose: May concern special identity or abilities, extreme wealth or a special mission and are associated with a strong need for meaning and purpose in life.

Control: People believe that their acts, motivations or emotions are under the control of another agency.

Religious: May concern a special relationship with God or gods but also sometimes involve claims of a special religious identity such as being Jesus; these kinds of delusions are notoriously difficult to distinguish from nonpathological religious beliefs.

These definitions make it clear that mainstream psychiatrists are characterised by delusions. Their predominant idiosyncratic beliefs are not shared by people considered sane - the general public and scientists - but the psychiatrists forcefully maintain them, even when reality, including the most reliable science we have, and rational argument and logic show that their beliefs are wrong.

It seems to have a persecutory delusional element when psychiatrists characterise people who criticise psychiatry as anti-psychiatry or conspiracy theorists.

Grandiosity is a sense of superiority, uniqueness, or invulnerability that is unrealistic and not based on personal capability. Many psychiatrists behave this way, believing in their own omnipotence and infallibility and that they have a special insight no one else has, particularly not their patients. If people disagree, they are seen as ignorant, in need of education.[1011] It is a bit amusing that psychiatrists say that their patients have no insight into their disease when they themselves have little insight into what their specialty does to people. I have experienced that very few psychiatrists understand the basics in clinical research. They therefore cannot assess what they read critically but do what their leaders tell them to do, which is what the industry wants them to do while they pretend they are evidence-based.

Faith is a great trust in something for which there is no proof, or an unshakeable belief in something even if there is proof against it. Clearly, the psychiatrists' beliefs in what they are doing are more of a religious nature than they are scientifically founded. This makes psychiatry a pseudoscience. Psychiatrists have an unshakeable belief in the great benefits of their drugs, electroshock and forced treatment, despite proofs of the opposite. Like members of religious cults, they don't listen to evidence that could shake their beliefs; they suppress it, distort it, or lie about it. Unsurprisingly, some critical psychiatrists find that psychiatry is a religious cult where people are excommunicated if thinking for themselves.

As I have already noted, one definition of madness is doing the same thing again and again expecting a different result. Virtually all psychiatrists do this. When a drug doesn't seem to work, they increase the dose, change to another drug from the same class, add another drug from the same class, or add a drug from another class. The science tells us that these manoeuvres do not result in better outcomes[1012] whereas increasing the dose or the number of drugs will increase the occurrence of serious harms, including irreversible brain damage, suicides and other deaths.[1013]

Psychiatrists often lie to their patients telling them that their disease might harm their brains, or they might die, if they don't take their drugs. This is perverse but it is getting worse. The use of psychiatric drugs and polypharmacy continues to increase markedly,[1014] and the mortality for patients with schizophrenia continues to increase.[1015] This is the not evidence-based medicine but madness. Two textbooks mentioned that several psychosis pills may be needed simultaneously, and one noted it may be appropriate in some cases to increase the dosage above the approved interval, which is also insane.

In 2006, a report from the Danish Board of Health showed that half of the patients were in treatment with more than one psychosis pill simultaneously,[1016] although both national and international guidelines recommend against it. The record I know about was a patient who took seven psychosis drugs. Nonetheless, our Ministry of Health issued a license to kill in 2014. It allowed psychiatrists to use extraordinarily large doses of psychosis drugs for forced treatment and said that this applies especially to patients who have been in prolonged treatment and where smaller doses have been tried without success.[1017]

This is as mad as it gets. This risk of death is of course dose related,[1018] and when drugs don't work, they should be tapered off, but this happens very rarely. Unfortunately, our authorities rely heavily on specialists when issuing guidelines, and they only make changes if critics make a lot of noise in public about the wrongs.

I have witnessed the madness directly in psychiatric departments. I was once invited to follow the chief psychiatrist during one day at a closed ward at my hospital, Rigshospitalet. One of the patients appeared totally normal and reasonable to me, but the psychiatrist considered him delusional. As I couldn't see this, he explained the patient was delusional because he had been on the Internet and had found out that psychosis pills are dangerous. I was so stunned that I said no more.

On another occasion, I phoned Psychiatric Centre Amager where the psychiatrists have killed several of their patients with drugs.[1019] A patient in great distress had contacted me, but I couldn't get a psychiatrist on the phone, even though I explained I was a colleague, and it was within normal working hours. When I insisted, I was transferred to a head nurse. She told me not to become involved because the patient was delusional. When I asked in what way, she said he had found out that psychosis pills are dangerous. I asked if she knew who I was. Oh yes, she did, but that didn't stop her from exposing psychiatry's insanity.

In 2023, the Norwegian Psychiatric Association felt so threatened by colleagues who wanted a radically different psychiatry that the whole Board published an opinion piece to defend the *status quo* in a newspaper, *'Pill shaming' is a serious societal problem*.[1020]

I wrote about the worst falsehoods in their misguided defence of psychiatric drugs.[1021] They denied that they change the personality (which is the reason for using them and which patients experience), have greater side effects than other drugs (they are the third leading cause of death) and are unnecessary (almost all of them are).

The psychiatrists noted that "Conspiracy theories abound that the pharmaceutical industry only wants to profit on making people as dependent as possible." This is not a theory but a fact. The industry has done what it can to create lifelong "customers."

"Drug treated patients return to work more quickly, and disability can be prevented" (a horrific lie, as the opposite is true).

"The prognosis and risk of relapse are improved significantly when patients take antipsychotics" (the trials that provide the basis for this misconception are deeply flawed).

"Patients with ADHD often have reduced quality of life, more frequent depression and more drug problems and criminal behaviour if they are not treated" (this is not true, and in the long run, the opposite seems to happen).

"Drug treatment makes patients more accessible to psychotherapy" (this has not been documented and is unlikely to be true, and if the drugs have caused permanent brain damage, psychotherapy cannot restore it).

"There is no biological basis for saying that commonly used psychiatric drugs such as antidepressants, mood stabilizers and antipsychotics cause dependence" (another horrific

lie; the drugs up- or downregulate neurotransmitters in the brain, which is why abrupt withdrawal can cause terrible and dangerous withdrawal symptoms).

"So far, most studies indicate that drug treatment is absolutely necessary to achieve recovery and increase quality of life and prevent relapse for most patients with severe psychiatric disorders" (these statements are also blatantly false).

The misconceptions among psychiatric leaders, not only in Norway but everywhere, are so much at variance with the scientific evidence, and with what the patients and their relatives and others experience, that it seems justified to say that the psychiatric leaders suffer from a very serious, collective delusion for which there is no cure.

Delusions are a key symptom for psychosis. Thoughts and perceptions are disrupted and people have difficulty recognising what is real and what is not.

So, here is a thought experiment. Using the psychiatrists' own diagnostic systems and practice, it can be argued that most psychiatrists should be forcefully treated with neuroleptics. If they tasted their own medicines, which some doctors have done to see what it was like,[1022] few of them would sustain their delusions about how good they are, which would benefit mankind.

I was an expert witness in a court case in Australia that illustrates psychiatry's insanity. A young man who should have been offered psychotherapy for his transient problems was functioning well when his psychiatrist put him on a depression pill for a depression he didn't have. His psychiatric "career" lasted 33 years before he finally succeeded to come off the last drug, but he still suffers from long-lasting withdrawal effects. He was prescribed a total of six different psychosis pills, five depression pills, and three sedatives/hypnotics, and developed Parkinsonism, likely drug induced. His psychiatrist stopped the drugs abruptly many times, which is highly dangerous. It is a remarkable feat that he survived this malpractice and continued being employed.

He should win the case easily, but unfortunately, judges are authoritarian and emphasise what other crazy psychiatrists do in similar situations. This is mad. If a bank defrauds its customers, the argument that other banks do the same won't exonerate the bank.

Occasionally, a case is won. Wendy Dolin in Chicago, whom I have met several times, sued GlaxoSmithKline after her husband, a highly successful lawyer who had no psychiatric issues, was put on paroxetine because he developed some anxiety regarding work. He got akathisia and threw himself in front of a train six days after starting paroxetine, not realising it wasn't him that had gone mad; it was the pill that had made him mad. I have also met with Wendy's lawyer, Michael Baum from Los Angeles, and collaborate with him. His law firm won the case, but GSK appealed, and the verdict was annulled, not because they didn't think it was akathisia, but they put the blame on the FDA. Wendy told her story at the international meeting I arranged in Copenhagen in 2015.[1023]

If usage of psychiatric drugs was sane, the usage patterns ought to be very different for pills against psychosis and depression because the main indications, schizophrenia and depression, respectively, are very different, the former being traditionally perceived as a chronic condition and the latter as episodic.

However, I found that the usage patterns are the same.[1024] I started the clock in 2006, when 80% of the patients in both groups had already been on a pill for one or more years. The percentage of patients that got a new prescription every year till they stopped or came to 2016, my last observation year, was the same, and after ten years, 35% vs 33% of the

patients were still in treatment. The usage patterns for benzodiazepines and similar agents, and lithium and stimulants (ADHD drugs) were largely similar.

These results are shocking. No matter which drug people take or what their problem is, roughly one-third of the patients are still in treatment with the same drug or a similar one ten years after several of them had already been treated for one or more years. This is a iatrogenic harm of epic proportions that tells a story of incompetent and irresponsible doctors who don't know what they are doing or what they are causing.

The data show an insane overuse of psychiatric drugs. But if you criticise this, the insanity just increases. When Scottish psychiatrist Peter Gordon in 2019 expressed his views about overmedication, the chair of the Scottish Division of the Royal College of Psychiatrists rang the Associate Medical Director of the NHS Board where Gordon worked and expressed concerns about his mental health.

Many of us have experienced to be "diagnosed" by our psychiatric opponents. For me, it happened during a court case in Holland where I was an expert witness (see page 147); in a conversation between two psychiatrists at a private party one of my friends overheard; and in a newspaper where Henrik Day Poulsen called me paranoid[1025] after I had published my book about organised crime in the drug industry.[1026]

Poulsen made a psychiatric diagnosis on me in the media, even though we had never met, and he also called me anti-psychiatry.[1027] He has published the book, *Drugs that kill*, about corruption and greed in the drug industry, but he doesn't see the irony that he participates in this.[1028] When I lectured in 2014 about happy pills, a previous patient said that Poulsen had written an autobiography. When I asked what it was, she said it was his book, *Everyday psychopaths*.

Half a year later, Poulsen triumphantly declared, in the same newspaper, with the headline: *Witch-hunt after the drug industry*, that I had lost my case against him in the Board of Medical Ethics, and he repeated that I, for a long time, had created a paranoid emotion against the drug industry.[1029] He didn't say what the case was about but pretended it had to do with my criticism of the drug industry, which was dishonest. And he celebrated too early. I complained to the Medical Association's Arbitration Court, which overturned the ruling from the Board of Medical Ethics saying Poulsen "violated collegial rules for doctors and used 'unnecessarily offensive and derogatory' expressions in a newspaper article and subsequent TV debate with me."[1030] Poulsen is likely the most corrupt psychiatrist in Denmark, as he collaborated the most with drug companies,[1031]

Two psychiatrists responded to Poulsen's ravings about my book in the article, *Corrupt and paranoid article*.[1032] Later that year, Poulsen said that "There is no risk if seriously ill patients in closed psychiatric wards receive antipsychotic medication in doses that are up to three times higher than the dose the authorities generally recommend."[1033] I believe Poulsen is so dangerous for his patients that his license to practice should be withdrawn.

Psychiatry is a madhouse. But not so much because of the patients who are either not mad, or their madness is often temporary, in contrast to the madness of most psychiatrists, which is chronic. Bob told me that a patient in an asylum once wrote: The psychiatrists called me mad, and I called them mad, and then they outvoted me.

That is the main problem. There are too many mad psychiatrists, and those who hold the power are the maddest. If only psychiatrists would listen, with an open mind, to their critics, patients and their relatives, much could be achieved. I shall therefore now convey a few funny stories about when people don't listen.

In 2013, during a lecture tour in North America, I lost my way at a hospital in Baltimore.[1034] I couldn't find the auditorium and the organiser didn't answer her phone. I strolled around in despair while the time for my lecture was rapidly approaching.

As a last resort, I bypassed a large queue of patients at the hospital reception, as I was in a hurry, and explained to the receptionist that I was not a patient, but a doctor scheduled to give a lecture in a few minutes time.

"Please go to the end of the queue," she replied with a stone face. I repeated that I was a doctor and asked for help to find my colleague who worked at the hospital.

"Please go to the end of the queue," the robot replied. It didn't matter to her how much I begged for help. As she didn't tell me the hospital information desk was close by, she might have thought I was a psychiatric case with the delusion that I was a doctor.

After having asked a friendly person in the corridor where the hospital information desk was, I arrived in the auditorium at the very last minute.

When I arrived at the McMaster Hospital in Hamilton in Canada some days later, I lost my way again. My colleague, Gordon Guyatt, had given me some instructions, but it was very difficult to find his office. I told the receptionist that I was a doctor and had an appointment with a colleague. After much trouble and disbelief, she reluctantly made a connection, and Gordon came down and picked me up.

He was on call, and when his pager howled a little later, I said jokingly that it was the receptionist who would tell him that his patient - me - had arrived. Quite so. I had become a patient once more, and my title as a doctor was disbelieved again.

With such attitudes to colleagues, it is easy to understand why psychiatric patients can become very frustrated when they are distrusted and why violence is sometimes triggered by the staff's disrespectful behaviour. Psychiatrists routinely refuse to trust what patients tell them about their bad experiences with the drugs they prescribe.

Danish philosopher Søren Kierkegaard wrote in 1859: "In order truly to help someone else, I must understand more than he - but certainly first and foremost understand what he understands. If I do not do that, then my greater understanding does not help him at all. If I nevertheless want to assert my greater understanding, then it is because I am vain or proud, then basically instead of benefiting him I really want to be admired by him. But all true helping begins with a humbling. The helper must first humble himself under the person he wants to help and thereby understand that to help is not to dominate but to serve, that to help is not to be the most dominating but the most patient, that to help is a willingness for the time being to put up with being in the wrong and not understanding what the other understands."

Few psychiatrists practice psychiatry this way, humbling themselves. Grandiosity is more common. A commentator wrote on *Mad in America* that psychiatry is predicated on how the psychiatrist "feels" about the patient and not how the patient feels.

Psychiatrists could improve a lot if they were willing to learn from their mistakes and to listen to their patients. Internet surveys of patients' experiences have revealed that drug harms are far greater and much more common than reported in the randomised trials, even though those who respond are generally quite positive to the drugs.[1035]

A previous patient wrote:[1036] "The worst have been those who sit with professional distance where they can neither give a little of themselves as a person nor have empathy for others. Far more people with user experience need to enter psychiatry, while those with anti-empathic professional distance must go."

I have learned a lot from the thousands of people, including progressive psychiatrists, that have sent me extraordinary stories about a specialty in ruins. Sometimes there were derogatory comments in the files about the relatives' personality, e.g. if they tried to avoid having their child treated with psychosis pills. Some have thanked me for saving a life, e.g.: "It was your book that gave us the courage to withdraw our son from antipsychotics." I later met with this person who is very active in the withdrawal community.

A patient who thanked me for having saved her life wrote that if she had not read my books and learned that there is something called withdrawal, she would have thought she had become insane.

Another patient wrote that her depression pill for shyness had made her life miserable. It changed her personality into being angry and disrespectful, and she lost many friends and her trust in psychiatry, drug companies, and doctors.

A family doctor used depression pills as a diagnostic test: If they worked, you had depression, and if not, you did not have depression. One would think it couldn't be more primitive than this, but another family doctor responded to a question about how to stop a depression pill: "You can just stop!"

A patient who had tried to withdraw twice from her depression pill in vain was told by her psychiatrist that she had a chemical imbalance and needed the drug for the rest of her life, and her psychiatrist even increased the dose. A substitute for her family doctor saved her. He said the pills were devilry and made her sick, and he helped her withdraw. She wanted to help others because she worked as a job consultant with unemployed people, many of whom got hooked on the pills because of stress and anxiety.

A father was denied custody of his children because he refused to take psychiatric drugs. If not illegal, it should be.

One patient wrote to me that a test showed her IQ had dropped to 70, but this was while she was doped when an IQ test is meaningless.

Another wrote that her psychiatrist had told her she had an incurable genetic disease, and when she complained that she could no longer concentrate, slept a lot, and had memory issues, the reply was that the problem wasn't the drugs but that she lost neurons due to psychosis. She therefore needed to take psychosis pills indefinitely to protect her neurons; otherwise, she would become demented. When she said she didn't want to take the drugs for the rest of her life, the psychiatrist replied that she would not see her anymore because she only worked with patients who wanted to be treated. When she had withdrawn the drugs, she was told she would have a new psychotic episode. Her father wanted to force her to go back on medication and threatened to send her to a mental hospital if she didn't follow the doctor's instructions. She lied to him saying she took the drugs again. Today, she is fine, having escaped the tyranny of incompetent psychiatrists and dumb relatives.

A patient wrote she had been advised to be on drugs for the rest of her life. When she told her doctor that they had caused anorgasmia, the doctor said: "Which do you prefer, not having orgasms or going mad?" She realised something was wrong and decided she did not want to live chemically castrated. After she had stopped all the drugs, she became herself again. She was no longer a zombie, was back to listening to music, laughed, sang in the shower, felt life, and had sexual pleasure. She had been sexually abused as a child, which is a common cause of psychosis.

A patient had taken fluoxetine (Prozac) for ten years, which changed his personality, and he lost almost all his friends. He went through a horrible withdrawal without help where he couldn't even get out of bed. His doctor told him that drugs were vital for him, like insulin for

diabetes, and he started on a drug again, but tolerated it badly. Then, his psychiatrist said that his ill effects were likely caused by his depression, and he wanted him to try another drug. This patient had attended one of my lectures in Stockholm and therefore knew I had a list of people who could help him withdraw.

An 18-year-old student was still grieving after his father hanged himself five years earlier. After he was put on sertraline (Zoloft), he tried to hang himself and a psychiatrist admitted him to a psychiatric hospital and increased the dose of sertraline. When a young psychiatrist noted that depression pills increase the risk of suicide, the consultant replied that they were aware of this but had to treat depression. If the student committed suicide without being on a depression pill, they would be questioned why he was not treated.

A middle-aged man with symptoms of pneumonia and a low mood was put on penicillin, sertraline and a sedative by his family physician. He developed psychosis with mania, was admitted to a psychiatric hospital and treated with olanzapine (Zyprexa). When a young psychiatrist asked if the psychosis could have been caused by sertraline, he was told: "I've never seen anybody with antidepressant-induced psychosis."

David Stofkooper from Holland took his life in 2020, only 23 years old. He had a flourishing social life, was a lively, very intelligent student, with a lot of friends, enjoyed socialising and loved listening to music. Since he was 17, he ruminated a lot but had a fun life.

He made the fatal mistake of consulting a psychiatrist who put him on sertraline (Zoloft). Within two weeks, he became suicidal, but his psychiatrist increased the dose, and it got worse. He became zombified, with no libido and no emotions; his whole personality had disappeared.

His mother called his psychiatrist and said the drug definitely didn't work, but she was fobbed off, being told she couldn't call due to her son's privacy. Her intervention was badly needed, as David didn't notice what was going on; he had lost himself totally.

David told his psychiatrist that he was very suicidal, but the psychiatrist said he needed to wait longer before the drug worked, so he believed in that.

After five months, he got a new psychiatrist who told him to quit sertraline cold turkey, in just two weeks. At first, he got a one-day long mania and told his mother he hadn't felt so awesome before. But after that, he got into horrible withdrawal, which went on for months. When he told his psychiatrist how he felt, she didn't believe him and said it was not due to the drug, as it was out of his system. She opined it was probably his obsessive, compulsive disorder that created all the problems.

David wrote in a suicide note that, "You present them with a problem that is created by the treatment you got from them, and as a reaction, get blamed yourself."

His life had stopped. He couldn't get pleasure out of anything. Although he didn't feel anything by meeting girls anymore, his zero libido and erection problems weren't even the worst part. It was "The total erasing of any pleasure in life."

When he realised, he was doomed to be in this state forever, he saw no other option than suicide. He was very rational about it, and his parents, who are both doctors, understood him.

The blunting of his emotions was fatal. He felt he was already dead, an empty shell. David had never had any sleeping problems before he took sertraline, but the drug caused severe insomnia, which lasted till the day he killed himself.

David wanted his story to be told, as a warning to others. Both he and his mother had read my first psychiatry book, but unfortunately, it was too late. If he had read it before he was put on sertraline, he might have refused to take the drug that killed him.

I have heard similar stories, also from Denmark, where the patients killed themselves because their sex life became permanently destroyed, and where they also experienced severe anhedonia (inability to feel pleasure), flatness of emotions, memory problems and cognitive dysfunction, which some of them described as a chemical lobotomy.

Patients who have come off psychosis pills have also sometimes complained of persistent sexual dysfunction. There is still a lot we don't know about the persistent harms of psychiatric drugs. But what we do know is that psychiatry is insane, which child and adolescent psychiatrist Sami Timimi wrote a book about.[1037]

## No hope for a better psychiatry in its current form

I have tried to change psychiatry from the inside, with no success. In 2016, I arranged a meeting with three members of the board of the Danish Psychiatric Association, including the chair and co-chair, to discuss issues we agreed about and where we might support each other. For me, the most important issues were to help all those who wanted to come off their drugs but couldn't because they had become dependent on them, and to reduce the use of coercion.

The meeting went well, and I was invited to visit the closed wards where the two chairs worked, which I did.

However, I was not welcome when, in December 2017, I applied for membership of the Danish Psychiatric Association. This should have been appreciated because, according to their own rules, "it is a task of the Association to further Danish psychiatric research, to ensure the best possible education of psychiatrists, to work towards providing optimal psychiatric treatment for the population, and to propagate knowledge about psychiatry."

Total silence. I sent a reminder, but the silence continued. After two months of waiting, I wrote to the entire board. The chair, Torsten Bjørn Jacobsen, replied that I did not work to further the aims of the Association. That was all.

Next, I sent a letter noting that they had violated their own rules, and I explained in detail the many ways in which I, to an unusual degree, had contributed to the aims of the Association. I also mentioned that, during their last annual meeting, an honourable member held a speech where he underlined that the psychiatrists needed to communicate with me.

Jacobsen replied that, "The board has emphasised the content and nature of your authoring business over the years, which contains opinions and views on the psychiatric specialty which are not in harmony with the Association's aims ... a basic element of membership of the Association must be that you respect the specialty and its accepted forms of treatment, which your authoring business does not live up to."

What a revelation! I knew it was unlikely I would succeed, but by trying, I uncovered what psychiatrists really stand for, behind all the official window dressing. It's like touching a spider's tubular net to see it come rushing out of its hide in the bottom. This was censorship and obstructionism, which reflected what many psychiatrists in training had told me. You are in bad standing if you criticise the way your colleagues diagnose and overdose their patients.

During the Association's general assembly in Nyborg three months later, Kristian Sloth asked why I could not become a member. He got no meaningful reply, but the audience applauded, nonetheless. As I was lecturing at the same hotel, offering two seminars about psychiatric drug withdrawal (see page 185), I had sneaked in and sat in the back of the room, hearing it all.

Three months later, the Association had a new chair, Gitte Ahle, and I applied again. To my point that no satisfactory explanation had been given at the general assembly, she replied that, "We do not share this view because people were satisfied with the oral statement as to why you had been rejected."

Interesting. Psychiatric patients are also told that what they have themselves observed is not correct because their psychiatrists don't share their views.

It felt a bit like when I went to Yellowstone with my family in 2006 and we flew into Salt Lake City. On a Sunday, there was church service in a Mormon church, and we wanted to participate out of curiosity to see what rituals this sect followed. When we were denied entrance, without the guards so much as asking if we were Mormons, I said: "I don't understand this. Did Jesus not say, let the children come unto me, and that the church should be open to everyone?" That didn't help.

The church of psychiatry is not for everyone either - only for believers in the rituals.

**Progressive psychiatrists**

I value highly the Critical Psychiatry Network, which was founded by a group of UK psychiatrists in 1999 to discuss proposed changes to the Mental Health Act. Currently the group consists of over 400 members, two thirds of whom are based in the UK.[1038] Membership is limited to doctors working in psychiatry or related fields, but on the recommendation of Lisbeth Kortegaard, I was allowed to join in 2013. Sami Timimi told Lisbeth that I would be "a fantastic addition to the CPN. Do you think he might be interested in joining our Network?" I saw it the other way around: It would be an honour for me to join this enlightened group.

Sami asked the secretary to add me to the membership, as I had "done some excellent analyses of psychiatric drug studies and the influence of the pharmaceutical industry."

The network was founded by Joanna Moncrieff and Tom Stockmann, and its current chairs are Joanna and Hugh Middleton. In 2015, Denise Winn did an interesting interview with Hugh, *Time to rethink psychiatry*[1039] after he published the book, *Psychiatry reconsidered: from medical treatment to supportive understanding*."[1040]

Hugh says in the book that psychiatry's core business is dealing with social phenomena, and when Denise asked him why we need a psychiatrist at the top, a medical person, when stress can lead to all sorts of symptoms and behaviours, such as anxiety, depression, anger outbursts, addictions and psychosis, he replied, "Perhaps we don't."

Hugh explains that a small number of people and the opinions they articulate have a disproportionate effect on the way resources are distributed, and that some psychiatrists have been formally disciplined for not using antipsychotics as much as the psychiatric establishment expect.

Hugh notes that "a stark lesson from the last half century's flirtation between psychiatry and biomedicine is that attempts to view and treat people who have difficulty living amongst others as 'diseased' are flawed ... biomedicine and other expressions of an 'illness' model do not offer an effective or acceptable alternative to doing the more difficult, but far more human and healing thing; understanding and reaching out to others in distress."

After having read books by Bob Whitaker and me, 46-year-old chief physician Klaus Munkholm from the psychiatric department at Rigshospitalet realised that what he had believed in for so many years, was not correct. He contacted me in 2017 with his concerns that biolo-

gical psychiatry had not been helpful for understanding psychiatric disorders, and he wanted to do meaningful research.

We met and started a fruitful collaboration. But it had repercussions for Klaus. He was discouraged from collaborating with my research group and was warned that it would have consequences for his career.

I told him that this was like religious fanatism. Jehovah's Witnesses and Scientology treat defectors the same way, which was unheard of in an academic context but told us a lot about where psychiatry is.

Klaus didn't budge, and five months later, I employed him one day a week. He was a great asset for our projects, and a year after he contacted me, I employed him full-time. Some of psychiatry's silverbacks, who had previously held him in high regard, now treated him as a heretic.

Another chief psychiatrist, Kristian Sloth from Randers Hospital, also asked to meet with me in 2017. He said that Psychiatry in the Capital Region had announced that depression pills can prevent dementia, which is impossible. Research has shown it is more likely that psychiatric drugs *cause* dementia.[1041]

Kristian had reduced drug expenses by 35% in just one year after he started working at the department. One patient with schizophrenia who had received a high dose of clozapine (Leponex) became psychotic, got even more of the drug and ended up in a maximum-security ward. When they stopped Leponex, the psychotic symptoms disappeared.

Kristian opened a section in his department called "force-free department" where the patients are not coerced. Kristian and his colleague, Anders Lindelof, did something radically different.[1042] They did not focus on diagnoses and drugs. They focused on the person they were talking to and on the relationships that had often been broken for the patient, asking, "What happened in your life that brought you here?" They did not look for faults in the person but tried to find the cause of the mental breakdown.

Their approach is based on the establishment of safe and stable relationships. All staff on the ward talked to patients and were committed to building good relationships and having meaningful conversations with them about their lives, about what they want, and about what is important to them - instead of just saying, "Have you remembered to take your medicines?" and hurry on to the next patient.

Kristian and Anders were so successful with this approach that they had available beds and said they didn't need more money. They wanted to tell their story to the management in the region but were not allowed to do so and sensed they were regarded as blacklegs. It was taboo to go against the eternal mantra in psychiatry, "Send more money."

Kristian and Anders listened to the lectures Anders Sørensen and I gave about drug withdrawal during the annual meeting of the Danish Psychiatric Association in 2018, and Kristian invited us to his hotel room afterwards for drinks. It was full of young psychiatrists, and some of them at first looked a little sceptical at us, but it wasn't long before they realised that we were not at all "dangerous," as they had been told by their bosses we were, but just wanted to contribute to creating a better psychiatry, like themselves.

Kristian's success threatened mainstream psychiatry. He was fired and smeared in the periodical, *The Freedom Letter*.[1043] There is not much freedom in using anonymous "whistle-blowers" who might have their own vested interests. Kristian was criticised for using benzodiazepines instead of neuroleptics for psychosis, but this is preferable, and for his view that drugs against depression and psychosis and admission to a psychiatric ward do more harm than good, but yet again this is what the science tells us. I don't know the details but suspect

that Kristian was fired because he practiced psychiatry humanely and rationally, with less use of drugs. When I discussed this with Kristian, I had a big laugh when he said that the only news in psychiatry the last 30 years was that they had needed to revise their hypotheses.

The psychiatric system is so sick that it punishes those who go against the drain and get better results than their colleagues by using less force and drugging less. Kristian has even been reported to the police. The patients and relatives smell blood, too, in the form of cool cash because it is alleged that he did something wrong. I suspect he is the victim of a witch-hunt and have argued that if the patient files at other departments were examined, the professional standard would likely be lower than at his department.[1044]

Clive Sherlock has a website, Adaptation Practice,[1045] where he explains that emotional, psychological, and mental suffering are not medical illnesses but normal reactions to life. His philosophy is that adaptation comes through practice, which has roots in the Far East.

Lee Combrinck-Graham, a retired psychiatrist, said that psychiatrists might ask: "What kind of psychiatrist are you, if you don't prescribe medicine?" And she would respond: "What kind of a psychiatrist are you if you don't talk to your patients, or, more specifically, listen to your patients and meet their family members or close associates, find out about them and include them in your ways of understanding what is going on? What kind of doctor are you if you don't look at development, adaptation, and the ups and downs in their lives?"

A young psychiatrist who came to see me quit her job at Glostrup Hospital where chief psychiatrist Lars Søndergård had so greatly overdosed the patients against the guidelines that he was fired and forbidden to work as a psychiatrist.[1046] She went to Slagelse Hospital, but Søndergård had been allowed to practice again, under close supervision, and he showed up there and continued to overdose his patients.

His boss, Michael Schmidt, failed to supervise him, and it was pure luck that he didn't kill any of his patients. Søndergård's malpractice included suspending the correct treatment of alcoholic delirium instituted by another doctor and starting treatment with psychosis pills, which in such patients markedly increase the risk of convulsions, cardiac arrhythmias, and death.[1047] Another patient was on methadone, which can cause lethal arrhythmias, and the Board of Health recommends against concomitant treatment with psychosis pills. Despite this, the patient was prescribed three psychosis pills and discharged the same day.

The nurses and Søndergård's psychiatrist colleagues were very concerned and contacted Schmidt, but nothing happened.[1048] As the culture at the department was one of fear and intimidation, the nurses involved their union.

Schmidt's reply to a journalist was extremely arrogant and showed that he was also dangerous for the patients.[1049] He could not "recognise" any of the horrible examples of overdosing the journalist sent to him.

It took four months for the Patient Safety Authority to respond to these concerns, even though patients might have been killed in the meantime. The verdict was harsh.[1050] Schmidt was placed under strict supervision and Søndergård could no longer work as a psychiatrist, at least not for a time.

Schmidt had approved a proposal from Søndergård that meant the patients became greatly overdosed, and he had been unable to interpret a scientific article from which he concluded the opposite of what the article said about dosage. Schmidt had also failed to inform the Authority of the excessive doses, even though it was his duty to do so, and the staff had made him aware of it several times.

Schmidt wrote to the Authority that Søndergård "has a sharp analytical approach" and had "brought the department to a higher professional level," contrary to the Authority's opinion that Søndergård had exposed some of the patients to serious danger.

Deputy Director Søren Bredkjær from the region issued a press release emphasising that they still had full confidence in Schmidt and that he had only received a mild sanction.

The young psychiatrist who contacted me had reported Schmidt to the Authority after having tried for months to solve the problems by taking them up with him. Schmidt's reaction had been to label her "an insane cantankerous person" in front of colleagues.

Eventually, she gave up and went to Bredkjær whom she encouraged to examine the relevant patient files. She showed him a list of the patients who were admitted on a day she was on duty and let him see her personal notes. She asked him to investigate the matter, but when nothing happened, she saw no other option but to go to the press.

Bredkjær talked mumbo-jumbo to the journalist and refused to apologise to the nurses and doctors who had warned about the problems but had been ignored, also by himself.

The worst bit is that what I have just described is in no way unique.

All the young psychiatrists who came to see me appreciated working with their patients. I told them they were exactly the type of doctors the patients needed, and that they should not leave psychiatry. One was severely reprimanded by her boss when she began to slowly withdraw the drugs the patients didn't need, which he had started in the outpatient facility.

Another psychiatrist wrote to me about his colleagues: "Can you imagine how it is to share coffee and lunch with these people, day in and day out?" He was forced to listen to their ramblings, and when he asked for the evidence, they became angry. Some always talked about colleagues who were bad at making diagnoses, but when he asked them how they knew they were correct, they became angry. "Worst of all, I need to listen to the lifestyle-oriented psychiatrists' talks about their apartments, cars, and travels, and they get angry with me if I even mention psychiatry. What I have painfully learned about these people is that most of them are completely uninterested in reading the actual articles about the clinical trials we have. Instead, they simply follow their leader."

Please pause for a moment. These, often ignorant, people are supposed to take care of our most vulnerable citizens, and they are allowed to use force. This tells us that we should abolish psychiatry and start from scratch. When a house is totally rotten, it won't help to try and repair it. We need to tear it down and build a new one.

In 2018, Joakim Börjesson, who did research with me on lithium in 2017, arranged a debate in Göteborg during the annual conference for 150 Swedish psychiatrists in training between clinical pharmacologist Professor Elias Eriksson and me about SSRIs.[1051]

Joakim had needed his diplomatic skills to arrange the debate, and especially to deal with Eriksson who is known for attacking his opponents violently. He told Joakim that he intended to reveal that I was a charlatan. Joakim discussed this with him for about an hour and "fruitlessly tried to convince him to adhere to the rules for the debate."

Eriksson was horrible. He claimed in his abstract that depression pills don't cause irreversible side effects; that they are not addictive; that criticisms are ideologically founded; and that their use according to the critics was the result of a worldwide conspiracy that included psychiatrists, researchers, authorities, and drug companies.

When I debated with Eriksson on Swedish radio five months earlier, he also lied, saying the pills help dramatically and can prevent suicide.[1052]

What is typical for debates with people who try to defend a sick system also happened here. Eriksson broke the rules, lied, and used dirty tricks to convince the audience that I could not be trusted. I mentioned that he had entered a secret agreement with Lundbeck against his university's rules, which meant that Lundbeck could prevent publication of his research if they didn't like the results.[1053] I said this because Eriksson routinely "forgets" to declare his conflicts of interest, but I was immediately stopped by the chair.

Later, the Ombudsman criticised the university for covering up the affair.[1054] Eriksson claimed he could not provide his correspondence with Lundbeck to a journalist because it had taken place on a Lundbeck server. If true, this was a highly unusual arrangement, and he lied about what a Freedom of Information request had addressed.

After the meeting, a psychiatrist wrote to me that you cannot convince religious people that there is no evidence for God's existence, but you can make them lose confidence in their priest if you can demonstrate that he used church donations to buy cocaine in a gay bar. He noted that, "Eriksson is a simple lobbyist who has made a fortune by playing political games rather than doing honest research, and he knows this himself. That is why he can lie about things he very well knows are untrue."

Joakim was unhappy that many of the psychiatrists had not understood my explanations about depression pills causing suicide. But when I present the same slides for a lay audience, they *always* understand them. The psychiatrists *don't want* to understand what is too painful for them. It was already too late to influence these young psychiatrists in training.

Seven years earlier, Bob Whitaker was speaking at a meeting in Malmö that child psychiatrists had arranged, but other psychiatrists intervened and got control of the meeting. Bob was forbidden to present any data on long-term outcomes of drug treatment. He went along with that, but when he arrived, he was told that Eriksson would be his opponent. Eriksson spent his time denouncing Bob. In Bob's own words, it was "a disgusting setup that stands out for its complete dishonesty, from start to finish." Eriksson declared that Bob was a "charlatan who tortures patients."

I had planned on attending, but Eriksson said he would not participate if I came!

**A new paradigm is needed for psychiatry**

In 2023, I explained why we need a new paradigm for testing psychiatric drugs.[1055] The short-term placebo-controlled trials with ineffective blinding, subjective outcomes assessed on rating scales, exposure of patients in the placebo group to drug withdrawal effects, and the reporting of results selectively has produced a literature plagued with misleading results that has resulted in tremendous harm for the patients.

Maryanne Demasi and Bob Whitaker thought my article was excellent. But when I submitted it to medical journals, the comments were so bizarre that I published the article, *How peer reviewers and editors protected a failed paradigm for psychiatric drug testing*.[1056]

None of the editors allowed me to challenge their sacred cow - the prevailing paradigm. Many comments were irrelevant or false, e.g. that drugs improve cognition; that psychiatric disorders are caused by a chemical imbalance; and that patients in schizophrenia trials are not exposed to a cold turkey if randomised to placebo. I was also told that I "undermined the vast scientific evidence of the beneficial effects of psychotropic drugs."

I argued that, in future, trials of psychiatric drugs should include only treatment-naïve patients; use psychotherapy or other psychosocial interventions as the comparator; use no rating scales, as they are not meaningful; use patient-relevant outcomes, e.g. returning to a

normal productive life; focus on drug harms; have a follow-up over several years; be planned and conducted by people with no conflicts of interest; and provide easy access to anonymised raw data so that others can check the veracity of what is claimed.

I consider the psychiatric drug epidemic the most harmful pandemic we have. It's even worse than our obesity epidemic, which doesn't change our brains and doesn't make some people so mad that they kill themselves or others.

Psychiatrists are drug pushers for organised criminals, Big Pharma. They persuade people to take drugs that will harm them, just like street pushers do with narcotics.

The time for diplomacy, with gentle suggestions of much-needed reforms in psychiatry, is over. It has been tried for decades and led nowhere. In fact, psychiatry has worsened and is harming and killing more people than ever before.

Revolutions don't come from people at the top of the power pyramid who benefit from the disaster they have created. The only hope we have is if patients, their relatives, and the public protest so that we get the necessary support from our politicians to start a revolution.

It means a lot for victims of abuse to get an apology. The psychiatric leaders should apologise for the immense harm they have inflicted on their patients by lying systematically to them. If they are unwilling to do this, governments should demand that psychiatric associations apologise unconditionally to the public as a condition for their continued support of this specialty.

Mental health issues are not medical issues. They should not be handled by psychiatrists, as they have a medical education, but by the caring professions and recovery mentors who have lived experience with surviving psychiatry and getting rid of psychiatric drugs. It is long overdue that psychiatry as a medical specialty gets disbanded. In evidence-based healthcare, we don't use interventions that do more harm than good, which psychiatry does.

Psychiatrists should be re-educated so that they can provide psychotherapy and other psychosocial interventions. Those who are unwilling to do this should quit, retire early, or be fired. As psychiatry is a crime against humanity, there should be penalties, including jail sentences in severe cases, for propagating false information or for drugging patients against their will, particularly if it results in death or permanent functional impairment.

The diagnostic systems, DSM-5 and ICD-11, should be discarded as they are arbitrary, unscientific, and harmful. We need to start all over again and make it simple, focusing on the patients' problems rather than giving them one or more labels that will stick to them forever. Formal diagnoses are not useless, but they should be simple and not of the current type: Find x faults out of y, or use some arbitrary score.

The main focus should be on helping the hundreds of millions of patients who have become dependent on psychiatric drugs to withdraw slowly and as safely as possible from them. We need 24-hour national helplines, associated websites, and drug withdrawal centres that provide free advice and support.

American emeritus professor of psychiatry and chairman of the DSM-III committee, Allen Frances, has stated that psychoactive drugs should not be prescribed by family physicians because they lack experience in their use.[1057] I agree. Not even psychiatrists can handle them prudently. The chair for the Danish Association for General Practitioners said in 2014 about depression that they didn't have "oceans of time" and couldn't set aside a whole hour for one patient, as they also needed to think of their economy.[1058] They therefore hand out depression pills liberally. This must stop.

Most psychiatric drugs should be removed from the market, as their availability does more harm than good, just like we try to keep narcotics away from our streets. Psychiatric

drugs should only be allowed for rare uses under strictly controlled circumstances, e.g. in acute situations; while patients are tapering off them; when it is impossible to taper off them because they have caused permanent brain damage; for alcoholic delirium; and as sedatives during invasive procedures.

Forced treatment must be made unlawful, as it kills many people and is discriminating and unethical, and all rules about demanding a psychiatric diagnosis to get social benefits, or extra economic support to schools, must be removed.

It will be a tough battle. Psychiatry's focus is on itself - a kind of false selfie it sends to the world all the time – it is about what will make life as a psychiatrist endurable. It should be about what will make the patients' lives endurable.

While the battle goes on, we will need to tell the public constantly that it is rarely a good idea to see a family doctor or a psychiatrist if they have a mental health issue, since there is a huge risk that they will be harmed.

**Having the last laugh at psychiatry**

It is easy to convince healthy people to take drugs they don't need for a disease they don't have. Australian artist Justine Cooper invented a hilarious hoax that looks like a TV commercial and advertises Havidol (have it all), with the chemical name avafynetyme HCl.[1059] Havidol is good for those who suffer from dysphoric social attention consumption deficit anxiety disorder (DSACDAD). Feel empty after a full day of shopping? Enjoy new things more than old ones? Does life seem better when you have more than others? Then you may have the disorder, which more than 50% of adults have. Havidol should be taken indefinitely. Side effects include extraordinary thinking, dermal gloss, markedly delayed sexual climax, interspecies communication, and terminal smile. "Talk to your doctor about Havidol."

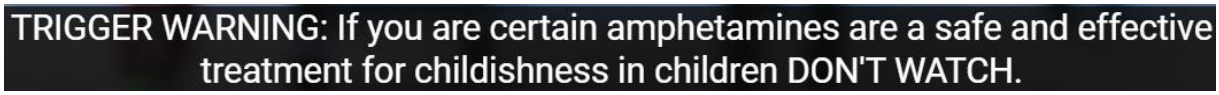
Some people believed it was for real and added it to websites for panic and anxiety disorder, or for depression.

Another hilarious video featured Australian journalist Ray Moynihan as a victim.[1060] It's about an epidemic – motivational deficiency disorder. In its mild form, people cannot get off the beach or out of bed in the morning, and in its most severe form it can be lethal as the sufferer may lose the motivation to breathe.

Moynihan says that "All my life people have called me lazy. But now I know I was sick." The drug is Indolebant, and its champion, neuroscientist Leth Argos, reports how a patient's wife telephoned him and was in tears. She said that after using Indolebant, her husband had mowed the lawn, repaired the gutter, and paid an electricity bill - all in one week. Although Moynihan described the new disorder in the *BMJ's* 1 April issue in 2006, [1061] some people believed it was a true disease and asked where they could buy Indolebant.

These satires come close to ads on American TV about psychiatric drugs. I showed them as an introduction to my talk about overdiagnosis and overtreatment when I lectured for over 100 psychiatrists in 2016. They laughed out loud but not when I added that what they had just seen wasn't far from their everyday practice. But we had a good discussion.

There is also a very funny video by Martin Whitely that mocks the ADHD pseudoscience and shows how absurd it all is.[1062] It starts thus:



# 10 More explorations in the bizarre medical world

## The powerless placebo

In 1994, *The Lancet* asked me to write a conceptual article about what placebo is as they planned a series of articles on placebo. I had not worked with this concept before, and the natural approach would have been to study what others had thought about it and provide an overview of the various ideas.

However, I lectured in Theory of Medicine, which included philosophy of science and ethics, and I was used to deal with basic issues in science. As I could not know if previous thinkers were sharper than me, I started from scratch during my summer holidays. I didn't read anything about placebo and was therefore not restrained in my thinking. I found out that it is impossible to define what placebo is in a consistent and testable way, without logical contradictions.

Having come that far, it was easy to write the article. I then read what others had written and found out that key placebo researchers – just like I noted 20 years later for key psychiatrists - are not logically consistent. I would have wasted my time if I had started the process with reading.

It was a highly rewarding experience. It is very rare you get an opportunity to think for yourself without being disturbed - excuse me but it's correct - by muddled thinkers who confirm one another about their misconceived ideas.

*Lancet's* editing was a bit heavy, and they abbreviated central themes so much that I was worried the logical chain of arguments would get lost on the readers. They even changed the title of my paper to: *Is there logic in the placebo?*[1063] No, there is usually lactose in a placebo or salt water if for injection! I think my title was better: *The logic of the placebo concept: is there any?* Which was what I had investigated philosophically.

Placebo is often defined as an intervention believed to lack a specific effect on the disease in question, but which is better than no intervention. However, this definition refers to the domain of beliefs rather than knowledge. Beliefs are common ingredients in placebo definitions, but they are not reassuring to a scientist. And we would have to say what we mean by specific, which leads to other, unsolvable problems.

Whether something is a placebo or not may depend on the outcome variable. Patients may enjoy drinking rum toddies when they have colds, but the cold doesn't disappear any sooner than without treatment. Thus, with a generic outcome such as patient satisfaction, rum toddy is a placebo, but with a disease specific outcome it is not. This suggests that we should not try to solve the essentially unsolvable problem of whether an intervention is a placebo but focus on the effect and choice of outcome instead.

I have seen many discussions in scientific papers and on email lists go astray because people do not use the concepts rationally and in the same way. For example, I would not call the positive effects of the interactions between a doctor and a patient placebo effects. They can be real effects, and some of this we call psychotherapy.

What goes wrong most often is when people say there is a large placebo effect because a trial that compared an active intervention with placebo showed a large improvement in the placebo group. This ignores the spontaneous improvement of the condition that would have happened without any intervention. Doctors also commonly speak about a placebo effect in individual patients, which they cannot know, as it might be spontaneous improvement.

If we wish to study the placebo effect, we must randomise patients to a placebo intervention and to a no-treatment group. Such studies often have a third group with an active treatment similar to the placebo. These studies are problematic because the patients cannot be blinded. A positive effect of placebo could be spurious because those who end up in a no-treatment group might be disappointed that they did not have a chance of getting the active treatment.

One of my PhD students, Asbjørn Hróbjartsson, and I published a large systematic review of the effect of placebo in *New England Journal of Medicine* in 2001.[1064] I did not want to publish in this journal, as I regard it as corrupt, but Asbjørn argued that, if only once in a lifetime, it would be nice to appear in the holy grail of medical journals.

Its editor, Jeffrey Drazen, is not a likeable man (see also pages 108 and 266). For some reason, he was against meta-analyses, and even though this is what we did, we were not allowed to use the word in our paper; it was changed to "analysis." Drazen was even more ridiculous when he, 15 years later, called people who do meta-analyses "research parasites."[1065]

Through a highly elaborate searching process, Asbjørn retrieved trials where the patients had been randomly assigned to either placebo or no treatment. He even convinced the US National Library of Medicine to rewrite its software so that he could search on "no treatment," which wasn't possible as "no" was not searchable. Experts had thought there were few such trials, but we included 130 in our review.

We started the project believing there were important placebo effects, but this was not what we found. Placebo had no significant effect on binary outcomes, regardless of whether they were subjective or objective. For continuous outcomes, placebo had a beneficial effect, but the effect decreased with increasing sample size, suggesting the small trials were biased.

In pain trials, placebo reduced the pain by 6.5 mm on a 100 mm scale. However, this effect, if real, is so small that it lacks clinical relevance. Asbjørn found that the minimum clinically important difference was 23 mm in patients with chronic pain,[1066] and 17 mm in patients with acute pain.[1067] So, even though the lack of blinding created a bias in favour of placebo, the measured effect was far too small to be of any relevance.

Before we undertook our review, it was widely believed that placebos were powerful, improving subjective and objective outcomes in up to 30-40% of patients with a wide range of clinical conditions, such as pain, asthma, high blood pressure, and even heart attacks. A very influential 1955 article in *JAMA* by Henry Beecher, *The powerful placebo*, concluded that placebos had a high degree of therapeutic effectiveness in 35% of the patients.

However, the vast majority of reports on placebos, including the *JAMA* article, had estimated the effect of placebo as the before-after difference in patients in a placebo group of a randomised trial.

Our review, *Is the placebo powerless?*, was frontpage news in *New York Times*:[1068] "In a new report that is being met with a mixture of astonishment and sometimes disbelief, two Danish researchers say the placebo effect is a myth."

Many people prefer to believe in myths. Statistician David Freedman said it could be misleading to do a meta-analysis, but this is the best method we have. He also said: "I think there's a big effect in many circumstances. This does not change my mind." Mr. Freedman, science is not about what you think but about what you find.

As Asbjørn told the *New York Times*, we began our study out of curiosity. Over and over, medical journals and textbooks asserted placebo effects were so powerful that 35% of the patients improved, on average, and we asked ourselves where this information came from.

Every paper referred to other papers, which referred to yet other papers. It was like peeling back an onion, finally finding the old paper by Beecher.

Our paper was threatening to people who had built careers on the placebo effect, and we spent quite some time during the next six years refuting flawed or erroneous analyses and invalid arguments.[1069] We also detected a case of fraud.[1070] The authors claimed to have shown an effect of placebo on hypertension in 2001 in 26 patients, but it turned out that there were 34 patients in their study, and in 1996, they had published a report that did not find an effect of placebo in the full sample. The 2001 paper did not quote the 1996 paper.

We also published a Cochrane review, which we updated, most recently in 2010, with 234 trials.[1071] It would be a waste of time to update it again, as the results are clear. The case is settled. Which is rare in healthcare research.

A good criterium for judging the usefulness of a paper is the number of previous papers it renders superfluous. On that count, our placebo review is extremely useful. It threw overboard 46 years of placebo research.

Our research on mammography screening also became frontpage news in *New York Times* in 2001.[1072] Because of my repeated appearances on the frontpage, also when we demonstrated that Pfizer had committed fraud with its antifungal trials,[1073] one of their reporters, Donald G McNeil, visited me in my home and wrote an article in the series, *Scientists at work*.[1074] In his article, *A career that bristles with against-the-grain conclusions*, he noted that I do not seem a man whose bite is much worse than my very gentle bark. "But this tall, gray-haired statistician is sending some eminent doctors into fits of apoplexy as he quietly implies that they've wasted their lives defending old wives' tales, maltreated their patients or assisted in frauds that perhaps ought to land them in jail." So true.

## The Texas sharpshooter fraud and other issues about unreliable research

In 2001, Douglas Altman and I participated in a *BMJ* editorial board meeting in London. In the evening, the dinner was followed by Scottish music on bagpipes. Doug and I were the only ones who weren't interested in dancing, so we talked about our research instead. He mentioned a project about comparing trial protocols to what was published, which research ethics committees had approved. However, a lawyer got wind of the project and stopped it, claiming the protocols contained confidential information, which they don't (see page 112).

I once had a PhD student who had planned to do the same but stopped for personal reasons. We decided on the spot to do the research in Denmark.

I was dissuaded to do it by an employee at the research ethics committee in Copenhagen who seriously doubted we would get anything out of it. He added that all the protocols had assembled dust in a basement full of spiders. "Fine," I said, "We'll work with the spiders." I hired a medical student, Mette Haahr, who collected the material. This resulted in six papers and a PhD for a highly talented doctor from Toronto, An-Wen Chan, who had obtained a Rhodes Scholarship.

Our research was ground-breaking. We compared 102 protocols for randomised trials with trial publications and discovered that two-thirds of the trials had at least one primary outcome that was changed, introduced, or omitted while 86% of the trialists denied the existence of unreported outcomes (they did not know, of course, that we had access to their protocols when we asked).[1075]

These serious manipulations were not described in any of the publications, and the changes we found were not exactly minor. A primary outcome, e.g. death or heart attacks in

a trial of a cholesterol-lowering drug, is a most important one, whereas a secondary outcome could be clinically irrelevant, e.g. serum cholesterol.

This was the first time this phenomenon had been studied systematically, and we were astonished that fraud was so common. What we uncovered is known as the Texas sharpshooter fraud. You fire a gun towards a target but miss it. Next, you wipe out your target and draw a new one around your bullet hole and present this to the public.

The reason this is so devastating for the trustworthiness of trials is that there are often many outcomes, which may be further divided or combined, creating even more chances of hitting the bull's eye. Moreover, 71% of the trials had at least one unreported outcome, and in these trials, a median of four efficacy and three harms outcomes were missing.

Our next study, which I submitted to *Science*, was also unique. The editor was very interested but offered us only 1000 words. When I tried to negotiate this, she lost interest. I sent it to *JAMA*, which offered us 800 words, which we accepted. We found that, in those 44 trials that were industry-initiated, the sponsor had potential control over a trial in progress in 73% of the cases.[1076] When the sponsor can peep repeatedly at the data as they come in, there is a risk that the trial will be stopped when it is most favourable, and indeed, trials stopped early exaggerate the effect by 39%, on average.[1077]

That the sponsor could stop the trial at any time was only noted in one of the publications. And none of the protocols or trial publications stated that the investigators had access to all the data generated from the trial or had final responsibility for the decision to submit for publication without requiring approval from the sponsor.

Constraints on the publication rights were described in half of the protocols, which noted that the sponsor either owned the data, needed to approve the manuscript, or both. None of the constraints were stated in any of the publications.

Even today, academics usually have their hands tied. They have little or no input into trial design, no access to the raw data and limited participation in data interpretation.

When I translated our paper and published it in our medical journal,[1078] the Danish Association of the Pharmaceutical Industry lost their mind, if they have one. They said they were "shaken and enraged about the criticism" that they could not recognise.

This was hypocritical. We had merely reported what the international drug companies write in their trial protocols, which the Association of course knew about. And if they didn't, they could easily have verified it. But they harassed us by filing a groundless case alleging we had committed scientific misconduct by deliberately distorting the data.

The Association copied some of its letters to the management at Rigshospitalet, where four of us worked, to the Copenhagen Hospital Corporation, the Central Research Ethics Committee, the Danish Medical Association, the Danish Drug Agency, the Ministry of Health, the Ministry of Science, and our medical journal. They spared our Queen and Prime Minister.

After we had been acquitted, they continued to insist we were guilty of scientific misconduct. Seven years later, industry people still lied about our research and acquittal. Stig Waldorff, a former employee of Astra-Zeneca, wrote in our medical journal that all the protocols noted that the clinical researchers made the final decision about content and conclusion.[1079] *None* of the protocols had such statements!

Waldorff's monstrous lie had the effect that Steen Græsted Larsen, my previous business partner (see page 38), offered all general practitioners in Denmark a free copy of my book about organised crime in the drug industry because they and their patients were the primary victims of the crimes. He described this in the article, *The deadly drugs*.[1080]

During all this brouhaha, a *BMJ* editor visited me and I told her about the non-existing "case" against us. She burst into laughter. She couldn't imagine why anyone would be foolish enough to accuse Doug Altman, their statistical advisor, and me of scientific misconduct. She asked me to write a paper about the affair, which I did. However, *BMJ's* lawyer was worried about possible litigation, and our paper was therefore transformed into an article written by a journalist.[1081] As I did most of the work, it was inappropriate that I was not an author, but I was happy that the Danish drug industry was ridiculed.

I explained in our medical journal how dumb and mendacious the industry association was.[1082] They stated three times, including in a press release, that they had not seen concrete documentation for our claims. This was untrue, as we had sent the documentation with examples to their press manager, Lars Bech Pedersen, before they propagated their lies. We asked the association several times to remove the false statements from their website, but this didn't happen, and we did not even get a response to our inquiries.

Lying is their business strategy. I was once asked by a journalist what my view was of the ethics in the drug industry. I replied that I couldn't answer, as they didn't have any.

Later, we noted that the association was failing its social obligations as a responsible partner in healthcare.[1083] They didn't make a single concrete point of complaint against our research but claimed they had not been able to reconstruct our results, which was yet another lie. It was impossible to go through the pages, we had seen without finding the documentation for our results. They could have strengthened their case considerably by submitting a letter to *JAMA* with different results than ours and by submitting their claimed different results to the committee handling alleged cases of scientific misconduct. We encouraged them several times to do this.

It was also wrong when the association claimed repeatedly that we had refused to hand over our protocol to them. We wrote that we would like to share our protocols with them, provided they would promise to share their protocols with those who requested them.

We published other revealing papers. For example, we found that unacknowledged discrepancies between protocols and publications were common for sample size calculations, methods of handling protocol deviations, missing data, primary outcome analyses, subgroup analyses, and adjusted analyses.[1084]

Ghostwriting was also common. It is the practice of hiding for the readers who wrote the paper to make it appear as if it came from disinterested, prominent academics and not from a corporate sponsor. It is very harmful to public health, as it misleads doctors about the benefits and harms of drugs. It is also fraud, as doctors are deceived deliberately.

None of the 44 trial protocols for industry-initiated trials or corresponding publications stated that the clinical study report or the manuscript was to be written or was written by the clinical investigators, and none of the protocols stated that clinical investigators were to be involved with data analysis.[1085] We found evidence of ghost authorship for 75% of the trials, which increased to 91% when we included cases where a person qualifying for authorship was acknowledged rather than appearing as an author.

The trial protocol is an important document, but only five protocols explicitly identified the author. None of these people - all of whom were company employees - were listed as authors of the publications or were thanked in the acknowledgements. When a little light shined on the ghosts, it was usually in the form of "XX provided editorial assistance," a euphemism for "XX wrote the paper," or the authors "thank XX for help," hardly with cooking coffee while the overburdened clinicians analysed the data.

What we uncovered based on the trial protocols shocked people all over the world, and there were many comments about our results in scientific journals and the media. There was also a foolish one, by Brian Moffatt, in the journal where we published our paper on ghost-writing. His critique was unwarranted as we had already addressed the issues he raised. We responded with the headline: *Criticism is unwarranted: Please read our paper again*.[1086]

Companies also use ghost writers to promote misleading trials in scores of secondary publications and reviews. Like the original research, these articles often carry the names of opinion leaders, which give them false credibility.[1087]

In 2005, when the UK House of Commons addressed the influence of the drug industry, representatives from GlaxoSmithKline and AstraZeneca declared that it is unacceptable to try to get a prominent scientist to put his name on a paper without having had any kind of involvement in the process.

However, drug firms should be judged on what they do and not on what they say they do. Two years earlier, three senior gastroenterologists received a letter from AstraZeneca asking them to serve as authors for an enclosed manuscript.[1088] Their names were already on the title page. It was propaganda concluding that AstraZeneca's proton pump inhibitor, esomeprazole, was significantly more effective than a comparator product for treating stomach ulcers. It was to be published in *Journal of Outcomes Research*, very likely a predatory journal, as it announced on its homepage that papers are peer reviewed in 7-10 days and that final acceptance takes 21 days, which is typical for such journals.[1089]

Omeprazole (Losec) was the world's best-selling drug, and when the patent expired, AstraZeneca launched esomeprazole (Nexium), which was not new at all.[1090] Omeprazole is a stereoisomer, and esomeprazole is the active half, a "me again" drug, which is patentable. AstraZeneca used illegal methods to keep competitors away, which included lying to patent lawyers, patent offices, and courts in several countries about the date when omeprazole had been given marketing authorisation. In the USA, AstraZeneca spent 500 million dollars in 2001 to market Nexium, which in Denmark cost 30 times more than Losec.

A drug cannot be better than itself, but the company managed to convince doctors to use Nexium. It is insane what happens in healthcare at the taxpayers' expense.

In 2006, I published a study on fraud in abstracts of scientific papers.[1091] As already noted, abstracts are very important because most people never read beyond them. In a random sample of 520 abstracts, the first result was statistically significant in 70% of the randomised trials, 84% of the cohort studies, and 84% of the case-control studies. Although many of these results were derived from subgroup or secondary analyses, or biased selection of results, they were presented without reservations in 98% of the abstracts. I also found that some of the results were false. This was large scale bias and fraud aimed at deceiving the readers. Medical research is nowhere near as successful as the abstracts indicated.

In 2007, we published another revealing study.[1092] Meta-analyses of randomised trials are considered the most reliable evidence we have, but how reliable are they? There is very little about this in the research literature, which is surprising. Meta-analysis of trials that have used different continuous or rating scales to record outcomes of a similar nature often use the standardised mean difference (SMD), which is the difference between two groups divided by the standard deviation of the measurements. Thereby, the data can be combined. If, for instance, a pain scale goes up to 100, the standard deviation will be about 20 times bigger than one for a scale that only goes up to 5.

We randomly selected two trials from each of 27 meta-analyses that had used SMD. 17 meta-analyses (63%) had errors for at least one of the two trials examined. We could not replicate the result for at least one of the two trials within 0.1 in 10 of the meta-analyses (37%), and in four cases, the discrepancy was huge, at least 0.6. Common problems were erroneous number of patients, means, standard deviations, and sign for the effect estimate.

For the 10 meta-analyses with errors of at least 0.1 in one of the two trials we examined, we checked the data from all the trials and conducted our own meta-analyses, using the authors' methods. Seven of the 10 meta-analyses were erroneous (70%); one was subsequently retracted, and in two, a significant difference disappeared or appeared.

The high proportion of meta-analyses with errors show that, although the statistical process is ostensibly simple, data extraction isn't.

Our results are very important, and our paper, published in *JAMA*, should therefore have been cited a lot in the scientific literature. As of July 2024, there were 23,750 records with *meta-analysis* or *systematic review* combined with *standardized mean difference* or *SMD* in the PubMed database, but our paper was only cited 152 times according to the Web of Science, or in less than 1% of the papers where a citation might have been relevant.

In 2007, we published another revealing study.[1093] In a random sample of 70 meta-analyses with a statistically significant result supporting a conclusion in favour of one of the interventions, we found that when we replicated the meta-analyses but only included trials with adequate allocation concealment (which means that the randomisation ensured comparable groups), 69% of the conclusions lost support. This mainly reflected loss of power (the total number of patients was reduced by 49%) but also a shift in the point estimate towards a less beneficial effect. This paper was cited 352 times.

In 2009, we published a study I am proud of that I conceived.[1094] It was an observer variation study where several people independently of each other did meta-analyses based on the same trials. We used a random sample of 10 Cochrane reviews that presented a result as a standardised mean difference (SMD), retrieved the protocols for the reviews and the included trial reports, 45 in total.

I invited 10 people to stay at a course centre north of Copenhagen where we worked for a week. Five experienced methodologists and five PhD students independently extracted data from the trial reports for calculation of the first SMD result presented in each review. They had access to the review protocols, where the relevant outcome was highlighted. As in our earlier study, we defined agreement as SMDs that differed less than 0.1 in their point estimates or confidence intervals.

The agreement was 53% at trial level and 31% at meta-analysis level. Including all pairs, the median disagreement was SMD 0.22. The experts agreed somewhat more than the PhD students at the trial level but not at the meta-analysis level. Important reasons for disagreement were differences in selection of time points, scales, control groups, and type of calculations; whether to include a trial in the meta-analysis; and data extraction errors made by one of the 10 researchers. In 14 out of the 100 SMDs calculated at the meta-analysis level, individual observers reached other conclusions than the original review.

So, disagreements were common and often larger than the effect of commonly used treatments. Our study is unique and immensely important, as we showed that a widely used instrument is not reliable, and it was published in *BMJ*. It is therefore very disappointing that it has only been cited 54 times, or in 0.2% of the papers where a citation might have been relevant.

When we studied the multiplicity problem again,[1095] we sampled 19 Cochrane reviews with an SMD result based on 2-10 trials. We extracted all the data that were compatible with the review protocol and used Monte Carlo simulations to calculate all possible SMDs for every meta-analysis. The protocols often lacked information about which data to choose. The median difference between the smallest and largest SMD results within a meta-analysis was 0.40 standard deviation units. Once again, we showed that there is huge potential for bias in meta-analyses using SMD.

Our first two studies of the reliability of meta-analyses are cited in the *Cochrane Handbook for Systematic Reviews of Interventions*,[1096] but not the most important one, the observer variation study, which is curious because statistician Julian Higgins is editor of the 659-page *Handbook* and was also one of the 10 investigators and an author of our paper. Perhaps Cochrane was too scared to admit that many of its reviews are unreliable?

In 2008, I peer reviewed a meta-analysis of topical NSAIDs.[1097] I pointed out that there was enormous statistical heterogeneity in the results of the trials; that the effect decreased significantly and substantially with increasing sample size; and that the authors needed to address this, which was a major compulsory revision. Their reply is publicly available. It shows how arrogant and wrong the authors were when they argued that their review was not misleading and that the bias didn't matter.[1098] They paid no attention to this problem but lumped all the trials. The fact is that there is no reliable evidence that topical NSAIDs have any effect, which I noted in a chapter about NSAIDs in a *BMJ* book.[1099]

In 2008, we compared industry supported meta-analyses of drugs with other meta-analyses.[1100] Unsurprisingly, the methodological quality of the former was so poor that industry-supported meta-analyses are not worth reading.

Composite outcomes, combining several components into a single measure, are often used in industry-sponsored trials, which is so problematic that we decided to study it.[1101] Of 40 included trials, 29 addressed cardiovascular topics. Only one trial provided a plausible rationale for the choice of components. The components were not of similar importance in 28 trials, e.g. in 20 cases, death was combined with hospital admission. Other major issues were change in the definition of the composite outcome between the abstract, methods, and results sections (13 trials); missing, ambiguous, or uninterpretable data (9 trials); and *post hoc* construction of composite outcomes (4 trials), the Texas sharpshooter fraud. Only 24 trials provided reliable estimates for both the composite and its components. In 11 of 16 trials with a statistically significant composite, the conclusion in the abstract falsely implied that the effect applied also to the most important component. This was an eye-opener. The use of composite outcomes in trials often deceive the readers.

In 2010, we published another unique study.[1102] I had lectured at a seminar on peer review and scientific misconduct at Karolinska Institutet in Stockholm and Fiona Godlee, *BMJ*'s editor, was also there. I suggested we investigate if substantive criticism in electronic letters to the editor, defined as a problem that could invalidate the research or reduce its reliability, was adequately addressed by the authors. A substantive criticism was raised against 30% of 350 research papers, but the authors responded to only 45% of these. There was no relation between the severity of the criticism and the adequacy of the reply, but the critics, whom we involved in our study, were much more critical of the replies than the editors ($P < 0.001$). We concluded that editors should ensure that authors they take relevant criticism seriously and respond adequately.

We also published a second study about lack of access to the data.[1103] We included all 69 industry-sponsored trials published in *The Lancet* in 2008-9. The editors helped us get access to the protocols, which described in 27 cases that the sponsor owned the data. In 67 protocols, there was no information on academic authors' access to data, in striking contrast to the papers, which indicated that one or more academic authors had access to the data in 64 trials. This was untruthful. Academics have consistently reported that they cannot get access to the data from the industry-sponsored trials they participate in, and a survey of US academic institutions found that trial agreements rarely ensured that authors had access to all trial data.[1104] Furthermore, the US drug industry association has stated that academic authors should be provided with summary data only.[1105] Entry of data into the study database was done independently by academic authors in only one of the 69 trials.[1106] In 11 trials, there was a discrepancy between the protocols and papers about who analysed the data. An additional 12 trials were industry-funded but seemingly independently conducted. However, in four of these trials, the protocol described sponsors' involvement in writing the report while the published paper explicitly stated that the sponsor was not involved. This looked like fraud.

Identifying, describing, naming, classifying, coding, and publishing adverse events in drug trials is challenging. As misclassification can have serious consequences, it is important that each of the many steps involved, from a patient's adverse experience to presentation in tables in publications, is as standardised as possible. So, what is the observer variation when several people classify and code the same adverse events? How reliable is the process? When we reviewed the literature in 2012, we found only one study.[1107] It reported that 12% of the codes (*Preferred Terms*) were evaluated differently by two coders, and a medical committee determined that in 8% of cases that the coders perceived as easy to code, the coding was nevertheless inaccurate.

## Regular health checks, a *Yes, Minister* parody

In 2007, the Danish drug industry association had convinced politicians they had lobbied that regular health checks are useful for disease prevention. Surprisingly, when a journalist asked if it was more about selling drugs, the industry spokesman confirmed this.[1108]

My lectures on Theory of Medicine created interest among the students in research methodology, and some of them wanted to do research. I had no shortage of ideas and ensured we published the research with the student as first author. Later, several of them became PhD students.

The first was Asbjørn Hróbjartsson (see page 224) who later became my deputy director. Another was Lasse Krogsbøll. He did a review of spontaneous improvement in randomised trials when he was a student,[1109] and I suggested he did a PhD on health checks. We had studied 56 Danish websites selling health checks, with another student.[1110] 17 of the 21 most used tests were unjustified, and in some cases, there was evidence *against* using them for screening purposes. None of the websites mentioned any harms and they presented a median of only one of the 15 information items recommended by the WHO and the Danish Board of Health when screening healthy people.

Health checks, called annual physicals in the USA, detect many things that should not be treated because they are either insignificant or will disappear again. In contrast to cars, our body has a remarkable capacity for self-healing, but, like health checks, car checks often result in large bills for unnecessary interventions. A friend of mine never had his old Volvo

checked - he got it repaired when there was a problem, which saved him a lot of money. I do the same. I only see a mechanic when I have to or for simple issues such as oil change.

We did not expect to find much but there were 14 trials with relevant outcome data that had compared health checks with no health checks in adults unselected for diseases or risk factors. We published our review in 2012[1111] and updated it in 2019.[1112] There is no reduction in total mortality (risk ratio 1.00), cardiovascular mortality (risk ratio 1.05), or cancer mortality (risk ratio 1.01). With 21,535 deaths, our results are very convincing.

There were no benefits either for clinical events, hospital admissions, or other measures of morbidity, but there were harms. More people got a disease label and more became treated with antihypertensive drugs. We concluded cautiously that "General health checks are unlikely to be beneficial," but in fact they are harmful and lead to psychological problems because people are told they are less healthy than they think.

In 2011, when our new government had regular health checks on the menu, I asked to have a meeting with the Minister of Health, Astrid Krag. I told her that our review, which we had just completed but not yet published, found no effect on mortality. I took a colleague to the meeting, Torben Jørgensen, who told Krag about a large trial he had just finished, which also failed to find an effect.[1113] The director of the Board of Health, Else Smith, participated in the meeting, but a few years later, when she was still the director, the Board manipulated the science beyond belief (see below).

Krag aborted her plans and said it was the first time the new government had broken a pre-election promise in an evidence-based manner.

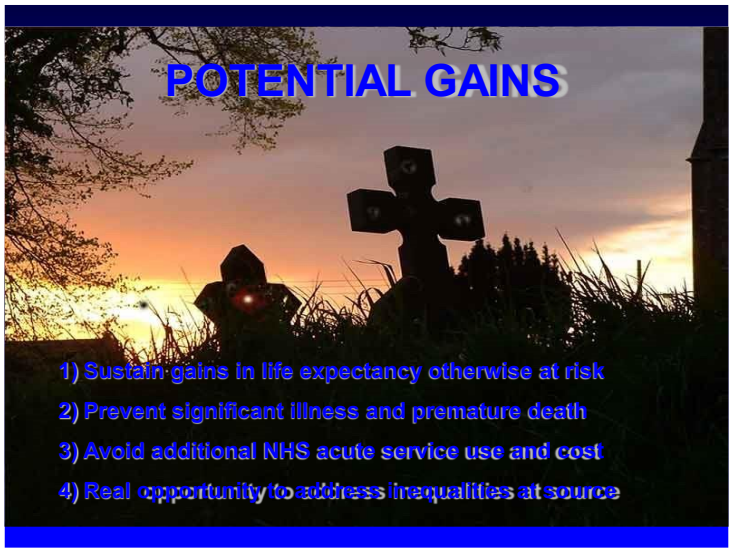
Our review saved billions for Danish taxpayers. But the same year, statistician Bjørn Lomborg arranged the Copenhagen Consensus Conference where three health economists concluded that health checks would give the most health for the investment, 26 crowns for every crown invested.[1114] Quite an impressive gain for something that doesn't work. We explained the elementary errors behind this estimate.[1115] It was based on a tiny trial we had included in our review, the Danish Ebeltoft study, which contributed only 0.4% of the weight in our meta-analysis of mortality. The economists calculated the number of life years gained based on an extrapolation from changes in risk factors, which is a wrong approach. Moreover, a review of 55 trials with interventions against elevated risk factors had not found less morbidity or mortality in healthy people.[1116]

The UK government didn't care about the evidence.[1117] The National Health Service offered universal health checks for people between 40 and 74 years of age who were tested for cardiovascular disease, diabetes, and chronic kidney disease. A slide show claimed that annual health checks would prevent at least 9,500 heart attacks and strokes, 2,000 deaths and 4,000 people from developing diabetes. There was a graveyard, so that no one would miss the gravity of what would happen if they did not attend health checks (see next page).

When our review came out, a Department of Health representative told *BBC* that, "By spotting people who are at risk of heart attacks, diabetes, stroke and kidney disease, we can help prevent them. The NHS Health Check program is based on expert guidance."

I see. The UK programme was based on evidence until our review showed it didn't work. Then, all of a sudden, the programme was based on "expert guidance" instead. Once something has been introduced as a national priority, it is very difficult to stop it. With a British understatement, the reactions in the UK to our review were "interesting." A year later, we had had enough of all the nonsense and published a letter in *The Times*,[1118] which resulted in a front-page interview: *NHS checks on over-forties condemned as useless*. It covered

almost half a page - next to a large photo of Prince William, his wife and child, and a royal dog.





THE TIMES

The woman behind that M&S campaign

NHS checks on over-40s condemned as 'useless'

Call for £300 million scheme to be scrapped

Name, set and match to Miss Sugarpova

In response to repeated calls for the programme to be scrapped, Public Health England announced that an expert panel was to be established to review the effectiveness and value-for-money of NHS Health Checks.[1119] Ministers now insisted that 650 lives a year could be saved[1120] - a sharp retreat from the previous claim of 2,000. The chief executive of Diabetes UK, Barbara Young, said that routine checks could uncover 850,000 people with undiagnosed type 2 diabetes. However, labelling almost a million healthy people as diseased has no value in itself, and we found that screening for diabetes is not helpful.

The attempts at finding a fig leaf and continue with the programme were now so bizarre that I published a comment in the *BMJ*:[1121]

"Public Health England will establish an expert panel to review the effectiveness and value for money of NHS Health Checks, and it will refresh the economic modelling behind the programme. We are furthermore told that 'although we recognise that the programme is not supported by direct randomised controlled trial evidence, there is nonetheless an urgent need to tackle the growing burden of disease which is associated with lifestyle behaviours and choices.' The truth, that health checks don't work and are likely harmful, is too much to bear for Public Health England, it seems. An expert panel is the modern version of the Oracle in Delphi, and statistical modelling is like whispering in a wizard's ear which result you would like to hear. Saying that there is an urgent need to tackle the growing burden of disease as an excuse for going against clear evidence from randomised trials reminds me of another episode of *Yes, Minister* where it was skilfully argued why a huge number of administrators were needed for a hospital that had no patients ... Like health checks, mammography screening is harmful, but such trifles don't affect the leaders of the NHS or the UK Government."

A month later, we alerted *BMJ* readers to the lack of fair play.[1122] The NHS Diabetes and Kidney Care and the Department of Health had issued an eBulletin, *Response to the Cochrane review*, on the NHS Health Check programme's website, but what appeared to be serious criticism of our work was unfounded and seriously misleading.[1123] We were even told it was inappropriate that we had included unpublished mortality data from a UK trial. This critique showed a disturbingly poor understanding of the fundamental principles for syste-

matic reviews. Searching for and including unpublished outcome data is very important, as negative results are less often published than positive ones.[1124]

We wrote to the director of the NHS Diabetes and Kidney Care and asked for our reply to be published on their website. This was declined. We were told that the government had already decided that "NHS Health Checks will be carried out as a national priority;" that the website is not a forum for debating the merits of such checks; and that "there are other more appropriate places to discuss government policy."

Since the website was not a forum for debating the merits of health checks, we wondered why the NHS had done exactly that, yet still denied us the opportunity to respond. And why the NHS programme did not publish its criticism in *BMJ*, where we had published our review, so we could respond to it. The answer is obvious: The NHS preferred censorship for an enriching debate, which they knew they would lose.

The absolute low point came five months later when the National Institute for Health and Care Excellence (NICE), supposedly an independent institution, behaved as the lapdog for the NHS and the drug industry in a press release:[1125]

"Helping local authorities to encourage people to attend NHS Health Checks and support them in making changes needed to improve their health, is the focus of a new NICE briefing ... providing the best value for money ... A report from Public Health England found that checking blood pressure, cholesterol, weight and lifestyle of people in this age group could identify problems earlier and prevent 650 deaths, 1600 heart attacks and 4000 diagnoses of diabetes a year ... The NHS Health Check programme is currently part of the health delivery infrastructure in England, so NICE seeks to support its effective delivery."

Prevent 4000 diagnoses of diabetes a year? Diabetes UK had just claimed that routine checks could uncover an estimated 850,000 people with undiagnosed type 2 diabetes. How does that add up? Are we supposed to find 850,000 or to avoid finding 4000?

One of my UK colleagues called the press release "Stalinism in the NHS" and referred to an article showing that members of Parliament were less gullible than NICE.[1126] They singled out NHS Health Checks as a cause for concern in a highly critical report, which noted that health professionals had been pressured to refrain from criticising the project in public. Regarding the poor uptake (only about 50% attended), Public Health England said its aim was to drive the acceptance rate up to 70-75%. That would not be possible without misinforming the public even more than before.

Despite all the *Yes, Minister* manoeuvres, people paid attention to our review and the media interest was phenomenal. Many websites, even in the USA - the motherland of overdiagnosis and overtreatment and waste of money - questioned health checks.

One of the poorest arguments I have often been exposed to when a systematic review shows that something doesn't work, is to criticise the included trials or the methods of the review, as if this would somehow magically render a negative result positive.[1127]

Torsten Lauritzen, key spokesperson for the tiny Ebeltoft study, wouldn't give up. His arguments were all false, e.g. that our screening tests and treatments were outdated and that the trials were old (we included all trials, also the newest ones).[1128] He referred to a meta-analysis of surrogate outcomes and to retrospective non-randomised comparisons, and talked about modelling studies, the standard "rescue" when results from randomised trials are unwelcome.

Lauritzen was amazingly stubborn.[1129] He carried on with his wishful thinking that health checks reduce mortality using modelling based on risk factors. He mentioned a systematic review of trials in general practice showing an effect of screening on risk factors for cardio-

vascular disease but failed to note that it also showed that 30% more people died from cardiovascular disease in the screened group than in the control group! As this difference was statistically significant, Lauritzen was scientifically dishonest.

He continued propagating misleading comments about our research and published a *State of the Art* article in our medical journal, which I would call a *State of the Garbage* article.[1130] He only mentioned his own study and an irrelevant diabetes trial that was not about health checks. This was cherry-picking in the extreme.

Lauritzen had many competitors to the Fool's Prize in this area, and one of them was our Minister of Health, Nick Hækkerup. He admitted to a speaker on health in Parliament that our review had not found any effect of health checks but added that the Board of Health had stated that this did not rule out that other forms of health checks could have an effect.

I noted that philosopher Bertrand Russell had pointed out how meaningless such statements are.[1131] He said we cannot rule out that there is a porcelain tea set in orbit circulating around the Earth. Scientifically, we cannot rule out that something might exist. But is it likely that there are UFOs or Martians, or a tea set in orbit? There was a cartoon in my article that was spot on. The man with the phone is from the European Space Agency and he says:

"It is from the Danish Board of Health. They ask what it would cost to launch a porcelain tea set for 12 into orbit?"


The Board of Health gave the minister a counterfactual fig leaf, which, according to my dictionary, belongs to the "department for nonsense." It rings hollow when the Board calls itself the country's supreme authority on health while it engages in politicisation at a nonsense level.

I asked the Board to get access to the documents, 30 in all, but was not allowed to see any of them.[1132] At the same time, a feature article in a newspaper criticised that civil servants did not hold on to "legality, matter-of-factness, professionalism and truth," but manipulated the evidence to embellish the government's image and advance its interests.

I complained to the ministry and got access to 14 documents, which included a smoking gun. It was about screening for chronic obstructive pulmonary disease, cardiovascular disease and diabetes, and it stated that early detection can lead to fewer disease complications, reduce mortality, reduce healthcare costs, and provide opportunities for a better life, improve the quality of life, and even stop the development of the disease. This totally

mendacious information came from our Board of Health! I therefore asked for access to the remaining 16 documents, which should not be a problem according to our law because the case was now closed.

The Board's reply was another smoking gun: Access to the documents would mean that the Board's professional advice could limit the minister's political range of manoeuvres; it could also limit the civil service's freedom in relation to professional advice, which could lead to deterioration of the professional advice the minister receives from civil service. Thus, there are very special needs for confidentiality, the Board argued.

I had never before seen such an admission that "professional advice" is unprofessional. One would expect the opposite, that people would tighten up if there was public insight into what they did. And if the advice is okay, the Board should be proud of it and have nothing against putting it on public display.

And yet, there was a third smoking gun: The ministry referred to a document which "was exchanged between the ministry and the Board in several different versions, which reflected the ongoing development in the work with "qualifying the initiative to introduce health checks." What? This is what the Americans call torturing your data till they confess.[1133]

I complained to the Parliamentary Ombudsman who supported me. After a year, I got access to the document, which was the fourth smoking gun. It referred to the Ebeltoft study and stated that health checks had a positive effect for men with a short education. This was a lie. In our review, we had included a WHO study with 60,000 male factory workers and 2511 deaths, and there was no effect. In the Ebeltoft study, there were only 92 deaths, and those with short education made up a minor part of these.

Then came smoking gun number five. The Board discussed our review in a very cursory, almost condescending way: "Some studies show that general health checks have no effect on health (among them studies from Glostrup Hospital and the Nordic Cochrane Centre)." Some studies? We had collected *all* the studies!

The government had announced that it would cooperate with "central actors in the health service" to clarify who would benefit from health checks. I strongly doubted that those of us who knew most about the matter and had provided the most reliable evidence would be consulted, and I was right. The Board only asked the Ebeltoft people for advice.

I wondered what the documents I had not seen contained. Were they even worse? Would that be possible considering the Machiavellian process I had already uncovered?

Hækkerup was very pleased that the Danish Society for General Practice had offered to assist with the work, but this was also incorrect. Only the chairman had announced this and several of the members called for his resignation because of it.

The Danish Society of Public Health wrote to the government and Parliament that they wondered why the government, despite massive knowledge of the lack of effect of health checks, had made a decision that was very costly and would mean that cuts had to be made elsewhere in the healthcare system.

Hækkerup was grilled in the media. He declared he was convinced that people would live longer. When a journalist pointed out that there was no evidence for this, Hækkerup replied that he was not a scientist but a politician. The journalist then said that he must rely on science: "Nah, I am an opinionated person," he replied. Imagine if the Minister of Transport had a fondness for bamboo and decided that the Fehmarn Bridge to Germany should be built of bamboo, with a remark that he was an opinionated person, not an engineer.

What should we do when ministers of health and civil servants distort the scientific evidence to an unbelievable degree and harm our citizens and our economy? I noted that

the new law about reduced public access to government documents introduced in Denmark in January 2014 was heavily criticised for undermining democracy and increasing the risk of abuse of power in the public administration.[1134]

I firmly believe that when our authorities comply with the whims and gut feelings, ministers and conflicted experts have, instead of being truthful to science, we must change our laws about openness in public administration and introduce stiff penalties for those who abuse their power, including ministers.

Hækkerup had talked to three renovation workers and asked them if they thought health checks would be a good idea. That was the positive evidence he had. When he announced this, he also said the men could pleasure their wives. Indeed, a minister for the people.

Hækkerup, a social democrat, succeeded to convince the government about introducing health checks to "vulnerable citizens." Luckily, we got a new government in 2015, a liberal one, which cancelled his foolish plan.[1135]

In 2014, *BMJ* asked us to write an article about health checks.[1136] It is counter-intuitive that health checks don't work, and there are two likely explanations. Many physicians already advise their patients and test for cardiovascular risk factors or diseases in patients whom they judge to be at risk when they see them for other reasons. Even brief counselling about smoking will make some people abandon their habit, and several of the trials we included advised the participants about this and other unhealthy lifestyles. Further, beneficial effects of screening could be outweighed by harmful ones, and type 2 diabetes is a good example. Our drug regulators approve diabetes drugs solely on the basis of their glucose lowering effect without knowing what they do to patients, although we know that several drugs, e.g. tolbutamide and rosiglitazone, increase cardiovascular mortality.[1137]

Our review did not include trials of geriatric screening, as they evaluated many other interventions in addition to screening, such as falls prevention and specialist drug review. A large meta-analysis showed that community-based multifactorial interventions significantly increased the chance of living at home and reduced falls and hospital admissions.[1138]

Thus, there might be niches where interventions could work, but these interventions are not health checks. We therefore called for stopping health checks. But Lauritzen had a political project. In 2017, a UK observational study had shown that more diagnoses were made when people attended health checks, and he advocated a similar study in Denmark.[1139]

Many people who view themselves as scientists behave as pseudoscientists because they try to reject strong evidence with weak evidence, which is about not losing power or face. The research literature, newspapers, and other media are full of these UFO tricks (see page 144). Many people believe them because they don't have a science education, and many that have one are unable to distinguish between good and bad science.

Observational studies are the commonest cause of harmful confusion. When randomised trials have shown something with great certainty that people with vested interests don't like, they often say that observational studies have arrived at the opposite result and discard the trial evidence. This is how the doubt industry operates.[1140] It pays corrupt researchers to carry out research whose only purpose is to sow doubt, e.g. by claiming that tobacco is not addictive; that there is no climate change; and that lethal drugs are harmless. The industry buys time while people die by using weapons of mass distraction.

My close friend, Flemming Lynggaard Petersen, accepted his employer's offer of a health check when he was 59.[1141] Prostate specific antigen was above normal, and he underwent

bloody and unpleasant biopsies, which were negative even though over half of men his age have harmless prostate cancer, which grows so slowly that it would never have presented any problems before they died from other causes.

But Flemming was now trapped. During many years, he had his PSA checked regularly, and when he complained about the uncertainly, his surgeon said that they could operate, give him hormones, or radiotherapy, which made him shout, “But there is nothing wrong with me; you don’t know what you are doing!”

He was so right. But it took me a long time and much patience to convince him that he should drop the regular PSA tests and follow my motto: “Don’t worry, be happy.”[1142]

It is common to promote screening for cancer without knowing if it helps. The USA had Melanoma Mondays where people were encouraged to have their skin checked for suspicious moles. We warned against this evidence-free approach noting that the incidence of malignant melanoma in Denmark had tripled between 1978 and 2008 whereas the annual number of deaths was constant.[1143] As there had been no major advances in treatment, this showed massive overdiagnosis of harmless cell changes. There were no randomised trials, and screening for melanoma therefore didn’t fulfil the official criteria for screening. Nonetheless, the Danish Cancer Society and dermatologists encouraged everyone to "investigate themselves and the rest of the family for changes in the skin at least every three months, which also applies to children.”

Screening is a big industry, and meaningless screenings often get celebrity endorsement. In the USA, most body parts have advocacy groups, politicians or athletes with campaigns and slogans promoting screening,[1144] and there is no mention of what the harms are, or if screening saves lives. I have explained elsewhere why it is a bad idea to screen for thyroid cancer[1145] and mental health disorders.[1146]

The Danish Board of Health lures the population by not calling it screening when they know it doesn’t work, but “early detection.” In 2016, the Minister of Health, Ellen Trane Nørby, said that efforts must be made to detect the first signs of dementia more quickly. This was after the director of the Alzheimer's Association had declared that it is "extremely important to make a correctly diagnosis timely,” and that it is “unbearable” if patients must "wait for months." I noted that screening for dementia and drugs for dementia don’t work and explained why screening would likely do more harm than good.[1147]

An issue that bothered me from my earliest days as a medical student was urinary dipsticks. I wondered why all newly admitted patients with no symptoms of urinary disease were asked to pee so that the nurses could test them for blood, sugar, protein, white blood cells and nitrite in the urine, which may suggest diabetes, asymptomatic bladder infection, bladder cancer and chronic kidney disease.

All diagnostic tests have harms, and positive findings can elicit additional investigations, which might be invasive and lead to unnecessary treatment, e.g. kidney biopsies, cystoscopies, unnecessary antibiotic treatment, long-term follow-up of inconsequential abnormalities, psychological distress, and in rare cases even death.

Thirty years and billions of dipsticks later, I suggested to Lasse Krogsbøll that he reviewed this. We did not find any useful data to assess the benefits and harms of screening with urinary dipsticks, which remain unknown.[1148] Lasse also looked at 67 recommendations of health authorities and specialist associations in nine countries.[1149] No recommendations were found for or against the use of dipsticks in health checks or upon admission to hospital.

According to the WHO, there should be scientific evidence of screening programme effectiveness and the overall benefits should outweigh the harms. Guidelines should therefore recommend against screening with urinary dipsticks but they don't.

Many other routine tests are also unnecessary. In 2011, the aim of the *BMJ's* Christmas Appeal was to make surgery safer by putting an oxygen monitor in every operating room in the world, "monitors that we know save lives."[1150] I wondered why the *BMJ* supported this initiative[1151] when a Cochrane review of pulse oximetry that included 22,992 patients did not find any effect on cognitive function, length of hospital stay, incidence of postoperative complications, or in-hospital deaths.

## Ritual circumcision of boys must be banned

In 2014, I participated in a hearing in parliament about ritual circumcision of boys, which shocked me so much that I explained in a newspaper why doctors have an ethical obligation to refuse to participate in this barbary.[1152] None of the arguments offered in favour of male circumcision at the hearing held water.

It was one of the most bizarre events I have experienced.[1153] A Jewish doctor, Henri Goldstein, and a Muslim doctor, Kamran Shah, agreed that circumcision was a very important part of their community. Others pointed out that it is a strange entry ticket to a community that you must cut something off yourself to join. Goldstein mentioned that 5-10% of Jews are not circumcised. I cannot imagine that they would not be welcome in the community and how would people know? Jews hardly have registers of circumcised people, and if Jewish men show up at a party or at the synagogue, there would not be a doorman asking them to pull down their pants to see if they were entitled to participate in the community.

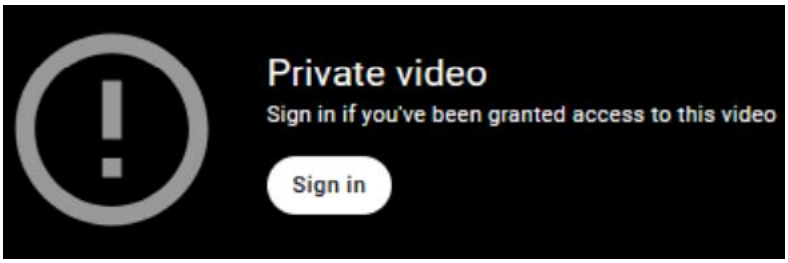
A Jewish mom regretted having her son, Leo Milgrom, circumcised, and when he grew up, he felt he didn't belong to the community. He mentioned that some Jews don't circumcise their boys but use another form of ritual that doesn't harm them, e.g. by giving the infant's foreskin a small prick instead. Goldstein countered that very few Jews use such a ritual, but this is beside the point. The great majority of Jews should learn from the small minority who think more about the welfare of the child than they do.

Someone mentioned that religion is man-made, and that Christianity has changed the perception of many things during history, so why shouldn't Judaism and Islam also change the perception of something that is highly inappropriate?

Kamran Shah, who, in addition to being a doctor, was also an imam and a representative of the Danish Muslim Union, sharply distanced himself from the idea of changing attitudes - which we have heard before from Muslims - and he stated that there are virtually no Muslims that are not circumcised. He argued that if circumcision is banned, we will see illegal "backyard circumcisions" under conditions that carry far greater health risks than if done openly. That argument doesn't hold. We have heard the same argument in relation to female genital mutilation, but that has not stopped us from banning the practice. Further, it has not led to an increase in the illegal, and riskier, circumcision of little girls.

Shah appeared nice and friendly but he was a wolf in sheep's clothing. He has explained that it is "haram" (sinful, i.e. forbidden by Allah) for good Muslim sisters to train to become social workers, health assistants, nurses, or medical laboratory technicians, because in these professions you come into physical contact with other people.

Shah's discriminatory attitude to women was documented in a YouTube video that was freely available in 2014. Perhaps it became too embarrassing for himself or his community, as what is shown today is this:[1154]




Shah preferred that women train as schoolteachers, so that there would be a lot of Muslim schools, which could counter the brainwashing that he believed was taking place in Danish schools. A more worthy representative of Danish Muslims could have been found for the hearing than this extreme imam who obviously did not like the country that had accepted him and treated him so well.

Else Smith, Director of the Board of Health, reviewed some of the medical evidence for circumcision and concluded that they could not, based on existing evidence, recommend circumcision as a health-promoting measure. But on the other hand, they saw no reason to advise against circumcision because the Board believed that the risks were very small.

This was countered by researcher in sexual health, Morten Frisch, who mentioned that the Board's note on circumcision from 2013 was full of embarrassing errors, inaccuracies, trivialisations, and serious omissions that gave way to religious groups' views on the matter. He pointed out that some children have died and that quite a few others have suffered serious operative complications. He referred to a report from Rigshospitalet, which showed that 5% of the children developed significant complications from the procedure.

Smith claimed that there had never been serious complications in Denmark, which was incorrect. The Board was aware of a case where an infant boy ended up in a coma at Hvidovre Hospital after a botched circumcision performed by a doctor at a private clinic in May 2014. Two months after the hearing, a man circumcised a three-month-old boy, which resulted in a life-threatening infection and admission to hospital.[1155] The man was convicted of serious violence in the district court and received a three-month jail sentence.

Frisch discussed the harmful effects of circumcision on sex life whereas Shah strongly recommended it due to the "fantastic evidence" there was for the many medical benefits. Even if there were, Jews and Muslims did not introduce circumcision to prevent disease. It is an ancient and harmful ritual, nothing else.

Philosopher Klemens Kappel delivered a very strange argument. He said it could be okay for parents to inflict suffering on their children if the aim is to strengthen a community. His argument can be used to legitimise circumcision of girls, and it also fits very badly with the fact that we have abolished the right to discipline our children physically. It is infinitely worse to remove the foreskin of a little boy than to slap him in the face.

Tyge Trier, a lawyer and expert in human rights, advocated that the child should have a say on the decision about circumcision, but he argued that the child was able to see the consequences of such a decision already from 7 years of age. This is not correct. Children that young will be highly influenced by what their parents think. Moreover, tattooing is

illegal in Denmark before the child is 18 years old, which is why circumcision should also be banned until the children reach adulthood and can make their own decisions.

Frisch pointed out that the mildest form of circumcision of girls is anatomically quite similar to circumcision of boys, and that it is inconsistent that we have banned one but not the other. In ethics, we are obliged to demonstrate that there is a relevant, principled difference between two situations if we believe that something is permissible in one situation but not in the other. So, also for this reason, the argument for maintaining the right to male circumcision falls apart.

Joachim B Olsen from a political party stated that there are examples of female circumcision being abandoned in some cultures, and he was interested in knowing if this - due to the much-mentioned importance of circumcision for the community - had had the effect that the culture had collapsed. Shah was asked to reply. He spoke for a very long time but avoided answering the question. Pressured by the chair, Mette Gjerskov, and the audience Shah then claimed it was difficult to comment because people do not ask such questions in Denmark, but he added that it had not been a problem abroad. Quite an interesting remark considering all the fuss there was about the importance of circumcision for the community.

Several international conventions can be considered when discussing circumcision, but they are not in agreement. The United Nations Convention on the Rights of the Child, which Per Larsen, chair of the Children's Council, commented on, is probably the most important one and also the strongest. It is a legally binding agreement setting out the rights of every child, regardless of their race, religion or abilities. It is clear from Article 24, paragraph 3,[1156] that you must not cause suffering to children:

"States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children."

Danish doctors' associations were generally highly critical of ritual circumcision when the Board of Health revised its *Guidance on circumcision of boys* in December 2013 and sent the draft around for a hearing. The Danish Society for General Practice has stated that "If circumcision is carried out without medical indication, it is mutilation." The Children's Council stated that the Board failed in its responsibility according to the Children's Convention, Articles 3, 4 and 19 (protection of the child against any form of violence) by not mentioning in the instructions what needs to be considered before a doctor participates in circumcision, which they found violated legal and ethical principles.

According to the Board, circumcision of boys is an operative intervention reserved for doctors. Remarkably, they nonetheless allow nondoctors to perform the circumcision if a doctor is present.

At Rigshospitalet, 315 boys were ritually circumcised from 1997 to 2003. Some of my colleagues have forgotten the most fundamental aspect of being a doctor: First, do no harm (primum non nocere).

In the USA, 64% of newborn boys undergo circumcision,[1157] even though only 3.6% of the population are Jews or Moslems. Many things are crazy in the USA but this is one of the craziest. Boston Children's Hospital list some potential benefits including less risk of getting penile cancer and HIV and over 90% reduction in the risk of urinary tract infections during infancy. These diseases are very rare and cannot justify male genital mutilation without informed consent.

Danish doctors and 80-90% of the population believe that non-medical circumcision of children under 18 should be illegal. Do something. Stop the barbary by law.

## Erasure of women by nauseating political correctness

Very few people have serious issues with their gender identity. But this has become a big issue, almost like a new fashion, and the political correctness is so nauseating that I decided to write about it.[1158]

In 2023, the US Preventive Services Task Force noted in their guidelines about mammography screening that they applied to "cisgender women and all other persons assigned female at birth (including transgender men and nonbinary persons)," apologetically adding that "the studies reviewed for this recommendation generally used the term 'women.'"[1159] The convoluted language means that the breast screening trials were done in women and not in men who feel they are women. Surprise, surprise. I had no idea that cisgender women means people "whose gender identity matches the sex they were assigned at birth." Since that is true for virtually all women, then why not just call them females? Breast screening is offered to those who have breasts, which we call women.

In 2022, the Task Force published the article: *Hormone therapy for the primary prevention of chronic conditions in postmenopausal persons*.[1160] There were no women in the article, only "persons." The EMA noted that those who have heavy menstrual bleeding are "persons,"[1161] but talked not only about "pregnant people" but also about "expectant mothers." What a mess. The WHO still talks about maternal deaths, but I guess it won't last long before "maternity bed" will be replaced by "person bed" or "people's bed," unless this gives unpleasant associations to Chinese dictators.

On 25 September 2021, *The Lancet* had this front-page:


It offended many women who felt dehumanised and denigrated, and Richard Horton, the editor, offered a lame apology emphasising that "transgender health is an important dimension of modern healthcare, but one that remains neglected. Trans people regularly face stigma, discrimination exclusion, and poor health, often experiencing difficulties accessing appropriate health care."[1162]

Whether transgender people suffer or not has nothing to do with talking about bodies with vaginas. On woman wrote that the message was unclear because female whales and cows also have vaginas, and because bodies might imply dead bodies. She also noted that in a tweet posted on prostate cancer only four days earlier, *Lancet* didn't refer to men as "bodies with penises … in fact, as it is only women that you describe in such terms, it is very clearly sexist ... *Lancet* has been captured ideologically by the gender identity lobby, which

denies the reality and indeed the social consequences and political significance, for human beings, of biological sex."

*Lancet's* owner, Elsevier, recommends that "For research involving or pertaining to humans, animals or eukaryotic cells, investigators should integrate sex and gender-based analyses (SGBA) into their research design" explaining that gender generally refers to socially constructed roles. I wonder how it could be possible for a male tortoise to see itself as a female tortoise and to communicate this to the researchers so that they can take it into account in their gender analyses. And how this could be accomplished for eukaryotic cells.

The stupidity is caused by the activism of an extremely small minority of highly vocal and intolerant transgender people who feel they have another gender than their chromosomes show. Two female professors have described the consequences of this activism and hostilities in a blog and journal article.[1163] Academics who have preserved their common sense, asserting that sex exists as a meaningful category, distinct from people's self-declared "gender identity," have suffered intimidation and been deemed transphobic. And questioning the position that a person's "gender identity" trumps their biological sex in legal and social contexts amounts to being "anti-trans," and to denying trans people's very right to exist. Strangely, those who have advocated for trans rights without denying the biological facts have faced some of the worst abuses from activists.

The mantra "Trans women are women" obstructs any attempt at a nuanced discussion about when sex is relevant. In a Danish court case from 2023, a man had received a custodial sentence with imprisonment for life after particularly dangerous rapes of women. He was allowed to legally change his gender even though no operations were carried out and complained that his inmates were all males demanding to be transferred to a section for females! The court denied him this.

Transgender activists have derailed academic debate with the hashtag #nodebate, claiming that debate constitutes real harm or even violence. This is very troubling given the need for research into the rapid growth in the numbers of young people presenting with gender dysphoria.

The universities have generally failed their obligation of fostering free academic debate and take appropriate disciplinary action against students and staff who engage in campaigns of harassment. Female students in particular have reported being unable to speak their minds in class.

In 2022, I was asked to participate in an Internet survey about research ideas for psychiatry. I needed to identify myself, and there were four options: male, female, nonbinary and "If none of the above options describe you, please self-describe." I couldn't resist the temptation and wrote: "I am a dog."

I like dogs. They are more honest than humans. A dog doesn't pretend it is a cat, and I have yet to meet a male dog that thinks it is a female dog. I wonder what the organisers of surveys will do when they report their results. Will they say that some of the respondents were dogs or tortoises, which I might use next time, as I loved the tortoises I kept when I was a child?

## Wasting money on ineffective and much too expensive drugs

The waste in healthcare on drugs is huge. Even though I have written numerous articles and have often been interviewed about the waste, and I documented that we could easily save billions on drugs without treating the patients any worse, very few political initiatives were

undertaken of any significance. Our drug expenditure continued rising steeply, totally at the mercy of the whims of the drug industry and those they have corrupted.

If we used medicines rationally, we would have much healthier and more long-lived populations. In 2012, the top 50 companies sold $610 billion in prescription drugs.[1164] We could easily save 95% of this, which are annual savings of $580 billion.

Many highly used drugs do not have worthwhile effects, and many others are 20 times more expensive than good alternatives. No one would pay 20 times as much for a new washing machine because the manufacturer had compared it with other machines and found his to be best.[1165]

Imagine what we could do for $580 billion. In 2022, only 23 countries in the world had a gross domestic product greater than this. More than $200 billion may be wasted on unnecessary treatment every year in the United States,[1166] and although it includes non-drug treatments and poor administration, it is one third of my estimate for the entire world.

I was a member of the Drug Committee at Rigshospitalet for 20 years. From 2000 to 2010, drug costs at hospitals increased more than 18% per year from 1 billion crowns to 5.5 billion. The drug industry's standard explanation for the high prices, that they are due to the large research and development costs, is a lie.[1167] The price of new drugs has virtually nothing to do with that[1168] but is a kind of extortion: What are politicians prepared to pay to avoid trouble in the media, denying patients access to drugs? The industry propagates the myth that it costs far more than $1 billion to develop a new drug, but the true cost is less than 10% of this, and over 80% of all funds for basic research to discover new drugs and vaccines come from public sources.[1169]

Some of the most expensive drugs we have were developed in publicly funded research, e.g. the first drug against AIDS, zidovudine (Retrovir), which cost up to €20,000 per year per patient when it came on the market in 1988. Now we have drugs that cost over €150,000 per patient.

**Recombinant activated protein C for sepsis**

A highly expensive drug for sepsis was recombinant activated protein C (drotrecogin alfa, Tigris, from Eli Lilly). When I mentioned in 2003 in our medical journal that the researchers had made important changes to the trial protocol while the trial was ongoing, which they did not tell their readers about in *New England Journal of Medicine*, and that the FDA had refused to recommend the treatment because of this, I was attacked by industry apologists several times, which I responded to.[1170]

Ten years later, the News section in the same journal announced that the drug was effective, and an anaesthesiologist, Jens Schierbeck, lamented that it was no longer on the market saying we had lost a potentially important treatment. I noted that what we had lost was all the money we had wasted on a drug that didn't work, which I confirmed in a meta-analysis: The risk ratio for death was exactly 1.00.[1171]

The change Lilly made in the middle of their trial happened when 30% had died on the drug versus 28% on placebo. They exchanged placebo for albumin, which increases mortality, and, lo and behold, the drug now reduced mortality significantly, 25% versus 31% mortality! It had been known for over a decade that albumin is harmful but when I described this fatal flaw in a letter to *New England Journal of Medicine*, they refused to publish it. This is typical for this journal. If they publish fraud, they surely won't admit it.

**Cochrane censorship and editorial misconduct: intravenous alpha-1 antitrypsin**

In 2008, intravenous alpha-1 antitrypsin was used in some countries for patients with lung disease caused by inherited alpha-1 antitrypsin deficiency. But it cost up to €116,000 annually per patient and its benefit was uncertain. Nonetheless, Danish lung specialists had successfully lobbied a political majority in Parliament to agree to reimburse the drug. As the deterioration in lung function is slow, and very slow if the patients don't smoke, the drug was to be used for many years in each patient.

The Committee on Health in Parliament asked me to review the trials before any decision would be taken. It took me only four weeks to write a report documenting that there was no convincing evidence that the drug worked. When I presented my results for the Committee, a Social Democrat argued that the drug should be funded because it was funded in countries Denmark usually compared itself with. I asked him which countries he alluded to. When he said Germany, I replied that Germans were also fond of homoeopathy and that we were not that foolish in Denmark. It amused the Committee members who were not used to such a pointed remark from a scientist, and they decided not to reimburse alpha-1 antitrypsin.

In the media, the Board of Health took the credit for having saved a huge amount of money for Danish taxpayers. My name was not mentioned even though I had saved at least €30 million every year.

I decided to do a Cochrane review about the drug with my wife Helle who is an expert in another chronic lung disease, cystic fibrosis. However, dealing with the Cochrane Cystic Fibrosis and Genetic Disorders Group was extremely difficult and frustrating.

The editors refused to send our research for peer review before we had found a third author who needed to be a content area expert. We explained we had plenty of access to experts, but that they didn't need to be co-authors. In fact, it would be impossible to add an author because we had already done the work. Such an extra person would have become a so-called guest author, a practice uniformly condemned by medical journal editors.

We noted that there had been a content area expert on our protocol, Asger Dirksen, who was first author on the only two trial reports that existed. He withdrew his authorship when he saw our negative results!

The Cochrane editors provided us with comments from an expert with numerous conflicts of interest in relation to the obscenely expensive drug we had studied. They even wrote to us that he would be willing to become co-author, which was outrageous. One of Cochrane's ten key principles is to avoid conflicts of interest.

As I couldn't persuade the group's editor, Alan Smyth, to move ahead, I described the case anonymously on the discussion list of the World Association of Medical Editors. There was no sympathy whatsoever with Cochrane's attitude. I complained to the Cochrane publication arbiters and to Cochrane's Editor-in-Chief, David Tovey, and the deadlock only ended when Tovey told the group to send our work for peer review without demanding a third author.

The editors were so unprofessional and incompetent, also in relation to elementary statistical issues, that I asked Tovey to transfer our review to another Cochrane group, which published it.[1172] I could not convince them, for example, that P = 0.06 spoke about as much against the null hypothesis of no difference as P = 0.03 (we had both P-values in our review, and the former indicated harm, the latter benefit of the intervention).

In 2024, the Danish Medical Council recommended using the drug because "there is a reasonable relationship between the value of the medicine and the costs of the treat-

ment."[1173] How is this possible for a drug that doesn't work and is highly expensive? Since we published the Cochrane review, only one new trial has appeared, and it is of inhaled drug.[1174] There were more exacerbations, more adverse events, and more dropouts on drug than on placebo. I often wonder why healthcare is so irrational.

Like me, John Ioannidis from Stanford University also had negative experiences of having content area experts in a review team. We published a paper in the *BMJ* where we warned against this, as experts may have personal prejudices and idiosyncrasies.[1175] We noted that the stronger the expertise, the stronger the prior opinion, the lower the quality of the reviews, and the less time is spent on them.[1176]

We also mentioned that when convincing randomised trials or systematic reviews find results that invalidate expert based practice, there is always a flurry of reviews, editorials, and letters from content area experts that try to refute, or even denigrate, the evidence. We gave examples of this wholesale editorial assault, one of which was my experience with alpha-1 antitrypsin. Moreover, experts tend to ignore the rigour of primary research and to praise papers of lesser quality that provide the results that confirm their beliefs, the UFO trick (see page 144).

When basic knowledge of an area being reviewed is needed, it can usually be acquired by consulting textbooks and reading review articles. And content area experts are happy to assist if review authors need help.

John and I noted that Cochrane stated in its handbook that review teams must include expertise in the topic area being reviewed and include, or have access to, expertise in systematic review methodology. We suggested the opposite: To include expertise in methodology and have access to expertise in the topic area. We also told our readers that we regard the theory of evolution as the most important discovery of all times and that Charles Darwin had no qualifications in biology. He studied medicine, law, and theology.

It is still a major problem that the freedom Cochrane groups have in setting their own standards sometimes lead to absurd demands that do not exist in other scientific journals. When I did a review of soft laser therapy for unwanted hair growth with a dermatologist, the Cochrane Skin Group told me they required a consumer as co-author. It is not clear to me why a woman with a hairy upper lip would become a good author of a scientific paper. We found one, but as she didn't contribute meaningfully, we dropped her as an author.[1177]

The Cochrane Anaesthesia Group required that all author teams must have access to a BSc, MSc, or PhD qualified statistician. I argued that I knew an excellent statistician who had no formal education in statistics and that I had authored 12 Cochrane reviews without needing support from statisticians, as I had studied statistics extensively. They accepted this.

**Corruption related to hypertensive agents**

In 2009, a journalist reported in our medical journal that the difference between the cost for the cheapest and the most expensive ACE inhibitor was a factor of 30 and that Denmark could save about €40 million a year by using the cheapest drug.[1178]

The chair of the Danish Society for Hypertension, Hans Ibsen, declared that we should be very cautious about changing drugs in patients with a well-regulated blood pressure. However, another hypertension specialist, Ib Abildgaard Jacobsen, who was not on industry payroll, said he had changed many patients' drugs without problems.

A year later, Ibsen noted that he initially supported the use of losartan, the first angiotensin II receptor antagonist, marketed by Merck, one of Ibsen's benefactors.[1179] When new,

similar drugs were introduced, Ibsen recommended those instead, although they were 10–20 times more expensive, with the argument that hypertension research would disappear from Denmark if we didn't use the expensive drugs. In this, Ibsen was supported by Novartis, another of his benefactors, which stated that Novartis conducted research to introduce their products on the market so that they would be used and that they saw no great future for trials in Denmark if there wouldn't be subsequent sales.

It was unusually frank that Novartis didn't hide that its "research" on expensive new drugs was just marketing. A colleague from *Doctors Without Sponsors* remarked about this that when the purpose of research was to teach the doctors to use much too expensive drugs, it might be better that the research was performed elsewhere. We could have saved €67 million in just one year if all doctors had used losartan.[1180]

Earlier, the industry, in close cooperation with corrupt hypertension experts, convinced many doctors that they should not use cheap, well-documented treatments like a diuretic, but expensive and poorly documented treatments.[1181]

Ibsen once attacked me in our medical journal saying I should be more positive towards the drug industry and acknowledge the important work sincere researchers did in collaboration with sincere drug companies. I asked what he meant by a sincere company and noted that he collaborated with Merck, Pfizer, AstraZeneca and Novartis, all of which had received giant fines for fraud, and that tens of thousands of patients had lost their lives because of the misdeeds committed by Merck and Pfizer.[1182] Since these patients died from cardiovascular events, which hypertension experts try to avoid, Ibsen should have refused to collaborate with such companies.

In his reply, *Peter Gøtzsche's type of debate*, Ibsen wrote that such rude allegations were not appropriate in a debate.[1183] I made no allegations. I presented facts, but, as usual, when I present an unwelcome truth, people often use my name in the title of their reply. They go after the man, not after the ball, which is out of reach for them.

**Fraud with NovoSeven**

In 2011, Novo Nordisk, the biggest company in Europe, even bigger than Maersk, agreed to pay $25 million to resolve its civil liability arising from illegal promotion of its haemophilia drug, NovoSeven.[1184] Haemophilia is a rare disease, but Novo promoted the drug, which contains coagulation factor VII, unlawfully to stop bleeding in trauma patients, resulting in false claims to be submitted to US healthcare programmes.

Novo paid influential army physicians to use and promote NovoSeven, provided illegal incentives for researchers, and engaged in a "fraudulent scheme to use kickbacks and off-label promotion" to boost sales, which trebled in 5 years and exceeded $1 billion in 2007. The activities involved speaking engagements, positions on advisory boards and unrestricted research grants for people working at the US Army Institute of Surgical Research.

In 2005, a trial in 301 severely bleeding trauma patients purported to show that NovoSeven worked.[1185] If true, it would have been sensational and we would have expected to see the trial published in a prestigious journal like *New England Journal of Medicine*, with huge reprint orders, and not in a little-known journal.

The trial report is a masterpiece in deception. The abstract is highly misleading and describes two trials, although it was only one trial. The data analysis was seriously flawed, using a new outcome that wasn't specified in the protocol (the Texas sharpshooter fraud, see page 226); there was an arbitrary cutoff for number of transfusions; and - unbelievably -

patients were excluded from analysis if they died within the first 48 hours! The data torture was gigantic and so clumsily made that it was easy to see that NovoSeven didn't work.

The fraud was funded by Novo and had a Novo employee and four physicians on Novo payroll among the authors. It was torn into pieces by experts, also in the journal where it was published, who spoke of "information laundering."[1186]

Novo's research director, Mads Krogsgaard Thomsen, claimed that it was the physicians who stood for the positive conclusions and that the company had limited input into the paper.[1187] This is not correct, and even the statistician was from Novo. The reason I could see the fraud so clearly was that a physician from my hospital had a copy of the trial protocol.

Some people believed in this mockery of science, and Novo embarked on a new trial, which my hospital declined to participate in. We had seen enough.

After having spent years pushing doctors to endorse off-label uses for NovoSeven, Novo issued a warning stating the drug could cause potentially fatal blood clots if used in patients who don't have haemophilia. But Novo denied any wrongdoing, and in a radio interview in 2008, Thomsen stated that the experts knew that the drug worked, which was why it was extensively used.[1188] An interesting comment from a research director in a company that created a blockbuster out of hot air. This is how proponents of alternative medicine argue.

**Anti-nauseating drugs at nauseating prices**

In 2012, the clinicians at my hospital wanted to use some highly expensive antinausea drugs as standard in patients receiving chemotherapy for cancer. One of the drugs, palonosetron, wasn't any better than the cheap setrons when heavy chemotherapy was used. My hospital nonetheless allowed the clinicians to use the expensive drugs in this situation, including one that cost 300 times as much as the cheapest one.

The clinicians were recommended to carefully consider when the expensive drugs should be used. Such advice has no effect when leading oncologists have been corrupted by industry money, which I knew was the case.

This was a typical example of the many outrageous decisions I witnessed before I withdrew my membership of the Drug Committee after 20 years of uninterrupted disappointments. No matter how shaky or irrational the arguments, or how expensive a new drug is, drug committees almost always please the clinicians. This is about avoiding trouble. Department heads are powerful, and if they raise too many complaints, top managers might lose their job. It also takes time to say no, which causes protests, and those at the top have too little time already.

I have discussed this with chairs of drug committees abroad who have also experienced a remarkable lack of management support for unpopular decisions.

We don't live up to our obligations and values as a profession. Drug salespeople may come to heads of departments and ask whether they will make an application to the drug committee, with the tacit understanding that those who refuse will be out of favour.[1189]

The nausea business is truly nauseating. The largest Cochrane review I have ever seen, 785 pages, was about drugs used for postoperative nausea and vomiting. It included 737 trials and around 100,000 patients, and yet, there was so much bias and fraud in the trials that the authors couldn't conclude anything about which drug was best![1190] One of the most prolific researchers, Yoshitaka Fujii, had fabricated his data in 126 randomised trials.[1191] Don't tell me medical research isn't "interesting."

**Any progress against cancer?**

There are many fanfares in newspapers and TV where cancer charities tout important progress against cancer. This benefits their fundraising activities,[1192] but the information is often dishonest. We hear a lot about that the survival after diagnosis has increased, but not that the clock starts earlier today than previously. The patients might not live longer. They only live longer with the knowledge that they have cancer.

If you get cancer, one of the most important issues is to decide if you should get chemotherapy.[1193] Almost all patients accept it, reasoning that if it wasn't worthwhile, it wouldn't be offered, which is a huge mistake. A 2004 review of the trials showed that the contribution of chemotherapy to survival of cancer patients in the USA and Australia was only 2%.[1194] In over 90% of the cases,[1195] the effect of chemotherapy was marginal, corresponding to a life extension of only three months.

People - including doctors - often say that a small average benefit can be worthwhile because some patients benefit more than others. This is a false hope. As cancer has highly varying growth rates, some patients are luckier than others. We can only make rational decisions if we base them on average effects obtained in randomised trials.

We also need to consider if a trivial life extension outweighs the harms of chemotherapy. My view is that it doesn't. Ending our lives at home by spending time with our loved ones - like my mother did when she died of breast cancer - is much better than being pestered by the toxic effects of chemo, resulting in frequent hospital admissions and dying in a hospital bed, which is an undignified exit. Unfortunately, chemo is given most intensely in the last few weeks before the patient dies.[1196]

It is not popular to tell the truth. When prominent doctors declared in 2012 that they would abstain from so-called life-prolonging chemotherapy if they got lethal cancer,[1197] the chair of the Danish Cancer Society, Frede Olesen, reprimanded them, saying they harmed the trust between patients and doctors.[1198] They didn't, quite the contrary. Why should patients not have the same privileges as health professionals? Few oncologists and nurses are willing to accept the chemo their patients endure for minimal benefit.[1199] For older patients, aggressive treatment is even more misplaced. What is most important to them is to maintain their independence and dignity,[1200] not a few extra intolerable weeks.

A woman, only 39 years old, said after four courses of chemo: "If this is my last spring, I'd like to put myself in the middle of it instead of having to go to hospital all the time." It was her last spring. I mentioned her in the article: *She got the last chemo on her way to the morgue*, which was how we joked about the overtreatment when I was a clinician.[1201]

Obituaries often say: "He lost the battle against cancer." We should drop the war rhetoric and say something positive, e.g.: "He had a good life even after he got cancer."

In 2010, the Danish Cancer Society asked me to review the evidence for regional chemotherapy, offered by Professor Thomas J Vogl in Frankfurt. At their own expense, hundreds of cancer patients had sought treatment there, e.g. chemotherapy injected into the liver metastases if they had bowel cancer. We concluded that there was no evidence that the treatment prolonged survival,[1202] and Vogel's scientific articles were of appallingly poor quality. There was no control group; no explanation of which patients he included; the data analyses were flawed; and he interpreted a decrease in tumour size as a benefit even though chemotherapy might shrink tumours while *increasing* mortality.

I thought that chemotherapy was quite effective for breast cancer until I looked up the evidence.[1203] A large meta-analysis reported that 3.0% fewer women had died from breast

cancer after 15 years if they received polychemotherapy, compared to other regimens.[1204] But, although the paper is extremely long, 31 pages in *The Lancet*, total mortality was nowhere.[1205] The readers were referred to graphs in a web appendix, but the paper didn't say where it was. This hurled me into the most bizarre type of playing hide-and-seek I have ever encountered. I used a lot of time on this and had given up when I decided to try one more time. I found the relevant graph in a document with 249 pages of graphs, with no meaningful legends or index to help readers find what they were looking for. The difference in total mortality was only 2.1%, which means that quite a few women had been killed by the polychemotherapy.

Two recent stories from my nearest family illustrate how absurd it can be to fight a battle you can't win. A 67-year-old man had incurable stomach cancer with metastases to the kidney and the liver. Even though nothing could be done, he underwent many diagnostic tests, which, due to their invasive nature, aggravated his condition. Several types of chemo were tried, and at one point he was offered "life-prolonging treatment." He perceived this message very positively even though the reality was that his life would not be extended. Yet, the false hope led to additional chemo regimens that pestered the last six months of his life. He did not have one single tolerable day.

My other relative was a 64-year-old man with pancreatic cancer with metastases. He wanted to try everything and underwent 27 radiation treatments. He asked to be operated in Germany, at no expense for him because there was a cooperation agreement. However, the surgeon experimented by mixing white blood cells with the cancer cells, reintroducing them via monthly injections "to strengthen his immune system." That treatment cost him a fortune. He died a year and a half after diagnosis, convinced he had been helped. Well, the surgeon certainly helped him lose his money.

Having a conservative attitude may sometimes not only improve the patients' quality of life but also extend their lives. A trial in patients with metastatic non-small-cell lung cancer showed that those assigned to palliative care instead of aggressive treatment lived three months longer.[1206]

**Fraudulent GSK trial of steroid for smoker's lungs and Cochrane fraud, too**

Smoker's lungs, or chronic obstructive pulmonary disease (COPD), is a gigantic market, about 400 million people.[1207] In 2007, GlaxoSmithKline (GSK) published a huge trial in the *New England Journal of Medicine* aimed at finding out if it was beneficial to give corticosteroid inhalations to these patients.[1208] The trial's name, TORCH, was suspicious: *Towards a Revolution in COPD Health*. How could GSK know this before they had done the trial?

The primary outcome was death. GSK randomised 6184 patients to four groups: placebo; salmeterol (a long-acting asthma drug); fluticasone (a steroid); and both drugs together. This factorial design is powerful. It allows the investigators to study three research questions instead of one, without increasing the same sample size. Such a trial can tell us if the two drugs are effective, and if the combination is better than any of its components.

But nowhere in the 15-page trial report was the correct factorial analysis to be found, and the abstract gives the readers the impression that the combination is better than any of its components: The combination had reduced deaths by 17.5% (P = 0.052 compared to placebo) whereas "the mortality rate for salmeterol alone or fluticasone propionate alone did not differ significantly from that for placebo." This was fraud. GSK did not provide the correct analysis in the main text of the paper either.

The authors of a letter to the editor reported the correct factorial analysis.[1209] The effect of the combination was entirely due to salmeterol and this effect, a 19% reduction in deaths, was significant (P = 0.004). Fluticasone did not work at all (P = 1.00). Another letter pointed out that pneumonia occurred more frequently when people received fluticasone (in 19% of the patients) than in the placebo or the salmeterol only groups (13%).[1210] The number needed to harm was only 17 (P < 0.001).

In their reply, the TORCH trial authors, which included an employee of GSK, committed more fraud. They said a factorial analysis assumes that each treatment has the same additive effect in the absence and presence of the other treatment and that this was not the case.[1211] They didn't verify their claim, and it was wrong. Other researchers documented eight months later that a factorial analysis was indeed appropriate, as the interaction term was not statistically significant (P = 0.32).[1212] They published this in another journal. I assume the editors of *New England Journal of Medicine* rejected their letter because it showed that the trial authors lied, which would reflect badly on the editors - who were complicit in the fraud, as they had published something that was so utterly and obviously misleading.

The trial authors claimed that the combination was superior, with fewer exacerbations and better health status, but this was also misleading. It was not superior for the primary outcome, death, and as it caused more pneumonias, it was clearly inferior. In addition, the secondary outcomes were not reliable because many patients discontinued treatment, and the analyses only included data up to that point, which is bad science.

What made me study this trial in detail was that GSK in 2013 published a full-page ad in a Danish industry-funded magazine that claimed that the combination (Seretide, called Advair in the UK), reduces the decline in lung function in patients with chronic bronchitis and would give them a better life.[1213] This was also fraud. The source of the lung function data was a post-hoc analysis of 86% of the patients in the TORCH trial.[1214] This analysis showed - once again - that the combination was not better than any of its components. A tiny difference of 3 mL (healthy people lose 30 mL per year) between the combination and each treatment alone was not statistically significant (P = 0.44 and 0.45, respectively). But the ad didn't mention these results. It said that the difference between the combination and placebo was statistically significant (P < 0.05).

The post-hoc paper had ten authors. Three were GSK employees, and the other seven were on GSK payroll, e.g. as advisory board members, speakers, and consultants. Two additional people, one from GSK and a ghost writer (euphemistically called a professional medical writer), were not listed as authors but were acknowledged for "technical support."

When I drew attention to the misleading marketing and research in our medical journal,[1215] GSK did not address any of my criticisms but stated that they were confident that the Danish authorities and specialists were fully capable of making decisions and guidelines that benefit the patients.[1216] They called their bullshit reply, *Openness and dialogue is the answer*. GSK had been anything but open, did not enter a dialogue with me or others, and committed fraud repeatedly to lure the doctors into using a drug that was double as expensive than the drug that worked, salmeterol.

One of the trial authors on industry payroll, Jørgen Vestbo, was aggressive and mendacious. Under the false headline, *The claims by Peter Gøtzsche about scientific article are untrue*, he argued that one should not do analyses that were not prespecified in the trial protocol,[1217] which was also false. The published protocol stated: "The other objectives of the study include comparisons of mortality in the SFC [combination] group with that seen in

the salmeterol and FP [steroid] groups, and in the salmeterol and FP groups compared with the placebo group."[1218]

In other such trials, both GSK and AstraZeneca failed to do the appropriate analyses,[1219] which means that the whole research area is a fraud. The crimes paid off handsomely. In 2012, the sales of the combination were four times larger than the combined sales of the two components.[1220]

The Cochrane Airways Group also contributed to the fraud by committing editorial misconduct. I submitted my criticism of the TORCH trial three times to the editors, but they refused to change the Cochrane review that was similarly misleading as the TORCH trial, which I explained in my published criticism of the review.[1221] The editors tried to dismiss my valid criticism by quoting the authors of the TORCH trial who claimed that a factorial analysis would not be appropriate. Oddly, they quoted the paper whose authors demonstrated that a factorial analysis was indeed appropriate, without mentioning this crucially important finding. I noted that I had downloaded the clinical study report for the TORCH trial from GlaxoSmithKline's website (5,481 pages), from which it is clear that GSK should have done a factorial analysis, also because the trial was clearly factorial in its design.

I complained to Cochrane's Editor-in-Chief to no avail, even though the Cochrane review is fraudulent. The authors implied that the combination drug lowers mortality even though the steroid had no role in this.

Cochrane is too close to the drug industry and has not even acknowledged that industry funding of trials is an important biasing factor. In 2013, Cochrane statistician Jonathan Sterne argued why the funding source should not be part of Cochrane's risk of bias tool. Sterne was out of touch with reality and the research in this area, which I noted.[1222] He showed his true face when he wrote: "Adding source of funding as a bias domain in the risk of bias tool would send an extremely negative message to pharmaceutical industry colleagues with whom we should be happy to work, and it might have the unintended consequence of labelling high-quality trials as biased."

It has been shown abundantly that many industry-sponsored "high-quality trials" are fraudulent. And why would we be happy to work with people in an industry that doesn't allow access to the data, not even for the doctors in hospitals that collected them?

**"Human guinea pig" asks GSK for its animal studies, but they don't exist**

A veterinary surgeon asked me to publish a story about inappropriate secrecy related to GSK's toxicology studies, which I did.[1223] He was a patient in a placebo-controlled trial of a new drug, darapladib, which GSK hoped would work for patients with a previous heart attack or similar problems. The vet believed he got active drug because he had diarrhoea, with a pronounced smell, which were known harms of the drug.

He wondered if he ran a risk of developing intestinal cancer, and at each visit to the hospital, he asked to see the animal studies. He was told that GSK would not provide this information, which he found so unacceptable that he stopped taking the drug.

When he contacted me for advice, I said he should ask his trial physician for the protocol and the investigators' brochure with the results from the animal studies. GSK replied that "It is GSK policy not to hand out a study protocol to non-site staff or persons as long as the corresponding clinical trial is being conducted, because the protocol may contain sensitive information from a commercial perspective." There is no sensitive information in trial protocols

(see page 112), and patients requesting to see the documents are partners in the trial. When GSK refused to provide the information, the patient suspected something was wrong with the drug.

I wrote to GSK that I had difficulty reconciling their reply to a request from a patient - who had run a personal risk by volunteering to participate in the trial - with its public announcements about openness and transparency, which GSK seemed to be proud of. GSK did not address my concerns but sent some bullshit about their interest in transparency.

Next, I requested information from the research ethics committee and the Danish Board of Health. They asked the contract research organisation (CRO) that carried out the trial on GSK's behalf, and GSK, if there was confidential information that needed to be redacted. The CRO said this was not the case, even though every page was labelled "confidential."

I received the toxicology section from the investigators' brochure and the trial protocol from the Board of Health and also from GSK in the USA. It emerged that a good reason why the vet was not given the results of the long-term animal studies was that they didn't exist. These studies began in tandem with the human trials. It also turned out that some of the animals had developed rare cancers in their small intestines, which GSK was concerned about but did not clearly address when they wrote to the investigators. GSK's information was hard to digest, and they also downplayed the risk in their updated patient information.

The data were clear enough in the investigators' brochure, and I found them worrying, as did the vet: "Had I known these facts, I would not have signed up as a participant in a clinical trial. That the rules were probably followed does not change the fact that they failed to inform me that there were no long-term studies in animals at the time when I first asked to see the results. That is both immoral and unacceptable."

He felt that he and 13,000 other people had served as human guinea pigs and that he had been misled when he was told that GSK would not provide the data.

GSK conducted another such trial. I find it unacceptable that drug regulators in over 30 countries allowed GSK to enrol over 28,000 patients before the results of the carcinogenicity studies in animals were communicated to them.

This story adds to the existing concerns that the social contract between patients and corporate sponsors of drug trials is broken.[1224] The patient consent form for the trial even stated that the research data were owned by GSK. Patients should not sign such a form, and doctors should not participate in such trials.

## Corruption, fraud and slave labour

Few people know how damaging and widespread the corruption in healthcare is. Almost every type of person who can affect the interests of the industry has been bribed: doctors, hospital administrators, cabinet ministers, health inspectors, customs officers, tax assessors, drug agency officials, factory inspectors, pricing officials and politicians.[1225]

Many patient organisations are also corrupt. In 2022, drug firms poured €110 million into groups in the EU, Norway, Switzerland and the UK.[1226] In 2024, I asked the Psychiatry Foundation in Denmark who their funders are, but they refused to tell me. Their annual reports only state that they receive private donations, not from whom. It stinks. What we do know is that, earlier, Lundbeck was a donor.

Corruption is most effective if it starts early. Students believe in what they read in medical textbooks, so it would be ideal for the drug industry if they could influence them. We studied this and found that 11 of 71 medical text-books written in Danish for graduate

clinical courses at the University of Copenhagen were sponsored.[1227] In three additional cases, the editors of textbooks that had no statements about sponsorship did not even know if the textbook was sponsored.

One editor - who was the sole author - was asked to rewrite a chapter that mentioned a drug produced by the sponsoring company. When he refused, the publisher rewrote the chapter and threatened with legal action if he protested. On top of this, the book did not reveal that it was sponsored. In another case where sponsorship was concealed, the company had the contents of a chapter changed in relation to recommending their drug through contact with the publisher without the author's approval.

In two cases, the textbook was available for free if the doctor agreed to receive a visit from a salesperson from one of the sponsoring companies.

None of the textbooks had any statements about the editors' or authors' ties to the drug companies. This is problematic as textbooks can be much more direct in their endorsement of specific drugs than research articles and seldom provide any data to justify it.

Even I became a victim of secret sponsorship. When my book with Henrik Wulff, *Rational Diagnosis and Treatment*, which was obligatory for the course on Theory of Medicine for medical students in Copenhagen, was translated into Polish,[1228] the publishing contract did not say it would be sponsored. Two of the most criminal drug companies in the world, Pfizer and GlaxoSmithKline, sponsored it. Sorry for being blunt, but it felt like I had been raped by drug lords.

Around 1990, I experienced myself how the industry buys friends. Investigators from several countries attended a one-day meeting in Paris where we discussed possible AIDS trials with a company that had invited us. When we went to a lavish dinner, the clinical trials director handed me an envelope, which I didn't open till later. It contained a letter thanking me for my contribution to the meeting and a $1000 bill. So, this is how it starts. You don't get more in the beginning than can justify to yourself, providing expert advice to a drug company. If you keep the money, you are game. Flattering company people will tell you how indispensable you are, and you tell yourself that the increasing payments are fully reasonable, until you no longer notice that the amounts have become obscene.

On another occasion, when we discussed an AIDS trial with a company, I suggested a protocol change, which was in the patients' interest, as it addressed the - undoubtedly negative – impact of the drugs on the patients' quality of life. To my big surprise, an Australian professor remarked that my proposal was not in the company's best interest. I was so baffled to discover that an academic investigator behaved like this that I still recall his name: David Cooper. In the coffee break, I discussed the event with some of my colleagues who were equally appalled as I was that Cooper put profits before patients, and one guessed on the amount of money he received by "consulting" for the company.

Cash leaves no trails. In 2000, I lectured at a course in Bern and met a woman who once worked for a Swiss drug company in Basel. She was asked to go to the Nordic countries with a stack of brown envelopes to be delivered to doctors who participated in hypertension trials. This was so weird that she asked what was in the envelopes. Dollar bills. When she asked why the company didn't transfer the money electronically, she was told she could leave the company if she continued asking questions. She left, to work with public health.

Other drug industry insiders have told me such practices are routine.[1229] A male oncologist at my hospital was nicknamed wall-to-wall Henning because he preferred to be paid in Persian rugs. By using far-fetched arguments that didn't hold water, he had prevented the

introduction of a far cheaper generic tamoxifen containing the same active substance as the original cancer drug.

The corruption of doctors is huge. In 2010, one in six doctors in Denmark had permission from the Board of Health to work also for the drug industry.[1230] Only 20,000 doctors had a license to practice in Denmark, but doctors worked for the industry in a total of 4,036 roles, which included 1,160 doctors who sat on advisory boards or were consultants and 1,626 who were clinical investigators.

Those doctors who decide what other doctors should do, are rather few, and as the industry buys doctors from the top, this comes close to total corruption. Very few doctors are needed for trials that are important – by far most of the trials are marketing disguised as science - and the industry can do quite well without employing doctors as advisors.

Once, when I lectured for laypeople, I told them that the Danish Board of Health called it a conflict of interest when doctors also work for a drug company, while in Norway, the Minister of Health called it corruption. They burst into laughter.[1231]

Doctors conveniently tend to think that by declaring their conflicts of interest, the problem goes away. Sometimes, they declare "Potential conflicts of interest," which downplays the problem and is a meaningless expression. A conflict of interest cannot be potential. It either exists, or it doesn't. Whether it has influenced what people do, is another matter, which is often impossible to prove.

Sheldon Krimsky noted that we wouldn't permit a judge to have equity in a for-profit prison, even if he disclosed it."[1232] We would not accept either a judicial proceeding in which the judge was paid by one of the corporate litigants, and lawyers are not allowed to work for both sides. But doctors have a remarkable capacity for denial. Disclosure is an empty ritual designed to ease the consciences of academics unable to wean themselves from industry payroll.[1233] Doctors are grasping at the straw of disclosure because it allows them to have their cake and eat it too, or they hide that they are corrupt. We found that 43% of the authors in industry drug trials had undisclosed conflicts of interest with a drug company.[1234]

Who would accept money "with no strings attached" from a robber who, in the act of stealing, happened to kill some of his victims? Who would accept money that has been stolen? Who would accept sponsorships from tobacco companies for a meeting about lung diseases? Few doctors would. Then why are most doctors willing to accept money from drug companies whose crimes have killed thousands of patients, the very people whose interests doctors are supposed to take care of? Industry liaisons also mean that doctors fail to notify drug regulators about serious drug harms. Some doctors send their reports to the companies instead, and the FDA and the EMA have found many cases where companies failed to send them on even when the patients had died.

In 2014, the average annual compensation for leaders of US Academic Medical Centers when they sit on drug company boards of directors was a staggering $312,564.[1235] This is not a printing error: over three hundred thousand dollars every year!

Corrupt doctors are often more extreme than the industry. In 2011, geriatrician Claus Moe wrote in an industry-sponsored magazine that the earnings of the drug industry are good for the gross domestic product and that patients should get the best rather than the cheapest medicine. He claimed that the Council for Use of Expensive Hospital Drugs, drug committees, and the Board of Health "are leading an almost crusade-like march" in a one-sided focus on savings, and he lamented that the industry was only allowed to talk about its products in hospitals if they had been notified in advance. Moe claimed that by using the

best medicines, patients get better faster; that it is not helpful if Denmark gets a bad reputation of using the cheapest drugs; and that Danish clinical research is threatened.

My PhD student Andreas Lundh and I replied that Moe's views were a faithful copy of what Director Ida Sofie Jensen from the Danish industry association usually says.[1236] We doubted that it mattered for our drug exports how little or how much we used our own expensive drugs in Denmark: "Does Moe really think that if the French decide to drink less of their own expensive wines, this will reduce French wine exports to Denmark?" We also noted that it is easy to give the patients the best medicine and save money at the same time, and that Moe was a lecturer for Lundbeck and Novartis and a consultant and lecturer for Norpharma, which he had not informed his readers about.

In 2011, the vice chair of the Danish Medical Association, Yves Sales, and I were invited lecturers at a meeting arranged by the Danish Society for Rheumatology. Opinions were divided about whether the society should continue to have industry-sponsored meetings, and they sought information and provocation. The title of the meeting was: *Collaboration with the drug industry. Is it THAT harmful?* The Danish industry association first declined to participate but sent its vice director, Henrik Vestergaard.

Troels Mørk Hansen told me there would be industry people in the audience, which would not appear in the list of 115 participants. Aha, so much for transparency! The industry prefers to operate in the shadows. A society called Young Rheumatologists had just held a meeting with about 30 rheumatologists and 60 people from the drug industry. Like the parents, so the children. During a pre-meeting dinner, Troels asked me not to be too tough with the industry. I smiled and said it was too late to change my talk.

I only went to sponsored meetings, if I had a chance of influencing the prevailing culture among doctors. In my talk, I addressed the five sponsors:[1237]

Roche was a drug pusher that had built its fortune on selling heroin to the underworld in the USA, shipping it as baking powder; had made millions of people hooked on Librium and Valium while denying they caused dependence; and had lured European governments into buying Tamiflu for billions of Euros for treatment of influenza, which I considered the biggest theft in European history because the drug is no better than paracetamol.[1238]

Abbott and its hired gun, cardiologist Christian Torp-Pedersen, blocked the access the Danish Drug Agency had granted us to unpublished trials of the slimming pill, sibutramine (see page 111), which was later withdrawn from the market because of cardiovascular toxicity.

UCB in Belgium had stated to us that it is an ethical company, and that all data are proprietary solely to the UCB who has the exclusive right to make whatever it deems desirable. I remarked that talking about being an ethical company and at the same time concealing trial data is bullshit. We performed a meta-analysis of a natural hormone, somatostatin, used for stopping bleeding oesophageal varices, and we discovered that the biggest trial ever done, a UCB trial, had not been published.[1239]

Pfizer lied at an FDA hearing about the cardiovascular harms of celecoxib; it agreed to pay a record fine of $2.3 billion for promoting off-label use of four drugs; it entered a Corporate Integrity Agreement with the US Department of Health and Human Services, which probably wouldn't work, as Pfizer had entered three such agreements previously. I explained that the reason Pfizer was the world's biggest company might be that it was more criminal than other companies.

Merck had caused the unnecessary deaths of tens of thousands of patients with rheumatological problems through its ruthless behaviour related to Vioxx; it selectively targeted doctors that raised critical questions about the drug; it concealed the cardiovascular risk both in publications and marketing; and the only thing that happened to its CEO, Raymond Gilmartin, was that he became immensely rich.[1240]

After these niceties, I fired a few more torpedoes about habitual fraud and crimes in the drug industry with devastating consequences for the patients and ended my talk by quoting *BMJ's* editor, Fiona Godlee: "Just say no" (to the free lunch).[1241] I also told the society that if they still couldn't see it was a problem to receive money from activities that were partly criminal, then why not get a sponsorship from Hells Angels?

Yves Sales supported me in the discussion. When the chair of the society argued that their meetings would be very expensive without industry support, Sales replied that there was no reason to shed tears if industry sponsorship was banned, and that it wasn't correct that the society couldn't arrange meetings without such support.

I drew attention to the fact that other academics educate themselves without industry largesse and noted that the general practitioners had observed that there was little difference in their costs after they had banned industry support of their annual meeting.

Vestergaard was very angry. He talked about my outrageous and insulting allegations, which is typical industry speak. Facts are not "allegations," and if it's insulting to tell the truth, the industry should change its habits, not me. Vestergaard refused to reply when I asked if it wouldn't be in his organisation's interest if fines for illegal activities became so high that they were perceptible. This would force the companies to compete at a higher ethical level, which would benefit industry, as it would become more attractive to work there.

Vestergaard used the standard tactic, hinted at the lone bad apple, and said that when the public purse wouldn't pay for postgraduate education, the industry had to do it. This hypocrisy was too much for a rheumatologist who remarked that the industry did it because it paid off, not because of some humanistic motive.

The passions ran really high. Merete Hetland, a rheumatologist with many industry ties, claimed I was employed to quarrel; that I threw suspicion on the industry; and that we were able to collaborate with the Germans although they were Nazis during the war.

Biological agents were highly expensive, around €14,000 a year, and a year before the meeting, the drug committee in Copenhagen recommended the cheaper drug, infliximab, whereas DANBIO's steering committee, headed by Hetland, referred to their observational data and claimed that etanercept and adalimumab were better. With Andreas Lundh, I wrote in our medical journal that observational studies are far too uncertain when assessing differences between drugs, and that DANBIO's study had been criticised. Instead of doing randomised trials comparing the drugs, the drug companies had chosen to contribute financially to the operation of the DANBIO database.[1242] Moreover, most people in DANBIO's steering group had received money from the companies that sell etanercept and adalimumab.

Andreas and I suggested that, instead of accepting lucrative consulting and advisory board positions in companies, the rheumatologists should free themselves from the pharmaceutical industry and demand that they do the relevant trials. But they could also do the trials themselves, which we believed was their professional obligation. I noted that our study of disease-modifying agents in 112 patients[1243] had only cost around €2,600 to do.

A year after the meeting, I looked at the society's homepage. It still had industry-sponsored meetings, and it was still possible for drug firms to become members. Provided they

paid 10 times as much as a doctor. Even in 2024, the society's annual meeting was industry-sponsored. Gosh, what a bunch of corrupt people these rheumatologists are.

When I worked at Astra-Syntex, we had a consultant, rheumatologist Jørgen Gylding-Sabroe, who got an annual honorarium corresponding to my salary in six months. I estimated that he didn't work for us more than a couple of days a year. He was positive towards our arthritis drug, so perhaps the marketing people felt they got value for money, which I doubted. He was not a leading figure and his main interests were in cooking and history.

The drug industry pushes drugs to all, even to young healthy people. Norwegians are some of the most long-lived people in the world but applying European guidelines for cardiovascular disease on a Norwegian population, researchers found that 86% of males were at high risk at age 40.[1244] In another study, 50% of Norwegians had a cholesterol or blood pressure level above the recommended cut-off for treatment at age 24.[1245]

The corruption of guidelines is often invisible. We found that 43 of 45 guidelines from 14 specialty societies had one or more authors with a conflict of interest related to the drug industry and 53% of the authors had them.[1246] Only one guideline disclosed the conflicts of interest. They were also of poor quality. Only 22% described the methods they used, only 60% had references in the text, and only 24% assessed the reliability of the evidence.

Doctors feel obliged to adhere to the many guidelines even though it is impossible to do this. Family doctors would need every hour of the day to live up to the recommendations from the US Preventive Services Task Force.[1247] There would be no time for taking care of those who are sick.

In 2013, I criticised NICE guidelines recommending drugs for urinary incontinence, which the drug industry has dubbed "overactive bladder,"[1248] which sounds nicer than wetting your underwear. The number of leakage episodes per day in the largest study was 3.2 on drug and 3.3 on placebo, and the number of pees was 10 versus 11 in the studies that reported on this.[1249] This is not a worthwhile effect, and it probably doesn't exist. How does a patient decide if a few drops of urine are a leakage or not? Given the conspicuous side effects of the drugs, many patients have likely guessed they are on them or not, and such unblinding would be expected to lead to substantially biased assessments in favour of the drug.

Frequent harms are dry mouth, blurred vision, constipation and confusion. Some harms can be serious and require a call to the doctor immediately: difficulty urinating, rash, hives, itching and difficulty breathing or swallowing. The drugs also lead to loss of balance, and about a fifth quarter of people who fall and break their hip will die from this misfortune.

These drugs should not be used. And NICE's advice is nonsense. Doctors should assess after four weeks if the patient is satisfied with the treatment. "If there is no or suboptimal improvement or intolerable adverse effects, change the dose or try an alternative drug, and review again four weeks later." This won't work of course. How on earth would a patient know if the drug works when it has no clinically perceptible effect? And what is the evidence that it would be helpful to switch to another useless drug? There is none.

A year later, a *State of the Art* review in *BMJ* by two US female urologists told us that "anticholinergic agents are the mainstay of drug treatment" if behavioural modification and pelvic floor exercises haven't worked and also that these drugs have been shown to be "safe and effective in the treatment of overactive bladder."[1250] This was *State of the Stupidity*.

I have been an expert assessing allegations of scientific misconduct in our national committee that handles such complaints. We had one of the oldest and best functioning systems in

the world, which was destroyed in 2005 by our Science Minister, Helge Sander, best known for having introduced professional football in Denmark and for inviting women for lunch tête-à-tête, at the ministry's expense, as an introduction for later pleasures. He also caressed women in parliament inappropriately to their chagrin.[1251]

Sander changed the law so that the committee was only allowed to accept allegations of misconduct involving private companies if they agreed to it. This caused an uproar and a flood of protests, even from Novo Nordisk, and the law was revised again in 2008.

In 2013, I called for yet another revision,[1252] with rejections and penalties for abusing the system in obviously groundless cases (see, for example, the non-case the Danish industry association filed against my research group, on page 227), and to publish all case files, which can prevent myth-making and injustice branding honourable researchers even after they have been acquitted (which also happened to us).

In 2017, it was suggested again in a planned law revision that private companies could not be investigated if they did not consent to it. I argued that in other matters, e.g. suspicion of tax fraud or murder cases, private companies did not have any such exemptions[1253] but got nowhere. The consent of the criminals is needed if they work in the drug industry.[1254]

Respectable medical journals avoid placing drug ads close to an article describing that type of drugs. When the editor of *JAMA*, Catherine D DeAngelis, visited me in Copenhagen, she told me she had been contacted by a very aggressive man from a drug company who insisted to have the two connected. She seemingly agreed, but it didn't happen. He phoned again, now furious, and she apologised that someone had made an error.

Current or previous editors of our top journals have exposed the corruption.[1255] Companies might call when they submit a paper saying they will buy reprints if accepted.[1256] In his paper, *Medical journals are an extension of the marketing arm of pharmaceutical companies*, *BMJ's* former editor, Richard Smith, explained that an editor may face a frighteningly stark conflict of interest: Publish a trial that will bring $100,000 of profit or meet the end-of-year budget by firing an editor.[1257]

Two thirds of the trials published in major journals such as *New England Journal of Medicine* and *The Lancet* are funded by the drug industry.[1258] In 2014, Richard and I argued why medical journals should stop publishing research funded by the industry.[1259] The *BMJ* and its sibling journals do not publish research funded by tobacco firms because the research is corrupted and the companies are oblivious of the harm they do. These arguments apply also to drug industry research, and flaws and fraud in the coding of adverse events can distort results substantially. This happened for adjudication of heart attacks in three pivotal trials of three different drugs. What was published in the *New England Journal of Medicine* was seriously misleading, compared to FDA analyses of the same data.[1260]

We suggested new ways to communicate trial results to doctors, without paywalls. Trial planning should begin with a systematic review of previous work, posted on the web for comment. If a trial was needed, the protocol would also be posted. The statistical analysis plan would be posted with the protocol and not made up late in the trial, when the sponsor might already have evaluated some of the data, and when the trial was done, the entire anonymised dataset would be uploaded for everyone to analyse. The role of journals would be to publish the results from the systematic reviews and contrasting analyses of the trial data by independent groups. To be respected, the journals would free themselves entirely from drug companies, as the French journal *Prescrire* has done.

*Annals of Internal Medicine* lost an estimated $1-1.5 million in advertising revenue after it published a study that was critical of industry ads.[1261] There should be no ads for drugs in medical journals, as they are harmful for patients and our national economies. Just let those journals die that cannot survive without them.

My PhD student Kim Boesen initiated a study of all 158 medical advertisements published in our medical journal in 2015.[1262] The most advertised drugs were not better than old drugs but were substantially more expensive, and 11 safety announcements for five drugs were issued compared to only one for a comparator drug. The managing editor, Bo Hasseriis Hansen, a businessman, was very unhappy with our results and refused to publish them.

We protested and after much negotiation, Hansen accepted a short report but without our calculation that showed it would not cost much for the subscribers if all ads were dropped.[1263] We had also suggested that the journal should not be printed but published on the web only, in which case the subscription fees could be reduced even without ads, but Hansen also deleted this.

In 2020, the Danish Medical Association announced they would drop drug ads. Doctors protested saying they were not influenced by them. We replied that if ads were ineffective, the drug industry would hardly have used 20 billion dollars on them in 2016 plus another 10 billion for direct-to-consumer advertising in the USA.[1264] From 2021, the journal no longer published medical advertisements. We were of course not credited for this victory for the patients and taxpayers.

Publishers of books and medical journals have ethical guidelines, which they routinely violate when they get in trouble. When your manuscript gets rejected, they won't tell you it's because they protect their income from ads and reprints, or because the editor or director has a well-paid position on the advisory board of a drug company. And when your paper gets retracted, they won't tell you it's because they have been threatened with litigation by someone with deep pockets or because a major benefactor has threatened to withdraw all collaboration with the journals the publisher owns.

Bioethicist and emeritus professor of philosophy Leemon McHenry told me that he and child and adolescent psychiatrist Jon Jureidini had a contract with Springer to publish the book, *The illusion of evidence-based medicine: exposing the crisis of credibility in clinical research*, but Springer rejected the manuscript with the excuse that the book was not academic. When asked how a book on evidence-based medicine and Karl Popper's philosophy of science failed to be academic, Springer replied with unusual boldness: "It is too critical of the pharmaceutical industry."

It used to be the drug industry that had the biggest return on investment, 19%,[1265] but the biggest academic publisher, Elsevier, had a profit margin of double as much, 36%, in 2010.[1266]

Medical publishing is corrupt; the profits are obscene; and it involves slave labour.

**Slave labour**

The surreal world of medical publishing involves slave labour. No other industry receives its raw materials for free from its customers (manuscripts), gets those same customers to carry out the quality control (peer review) of those materials for free, and then sells the same materials back to the customers at a vastly inflated price. Even if they just want to read one of their own articles, scientists will need to pay, typically around €40.

Springer is a superb extortionist. In 2020, *Nature* journals announced their open access option at a cost of up to €9,500 per article,[1267] the price of a good used car. This was after *Nature* had spoken about their "diversity commitment" pledging "greater representation of currently under-represented groups" and "faster movement in the direction of equity." The publication fee is the net annual earning of scientists in many African institutions and the annual salary of an assistant professor in a medical school in India.

Sometimes, smart academics also try to make colleagues work for free. In 2020, Joel Faintuch from Brazil invited me to contribute to a book about scientific misconduct, to be published by Springer. I was puzzled by his message that said that because it was a scientific book, there would be no royalties. So, Springer takes it all? Not quite. I asked, and it turned out that Faintuch and his co-editor with the same surname, Salomao Faintuch, would get royalties, which they "forgot" to tell us about. I replied that they were asking me to work for free for them, so that they could earn the money, and I reminded them it is many years ago they had slaves in Brazil. Using artificial intelligence, I found out that they are father and son and that they have edited numerous books together.

The same year, Daniel Dunleavy from Florida invited me to contribute to a Springer book about withdrawal of psychiatric drugs. The Springer setup for slave labour was that only Dunleavy would get paid. Springer generously promised the authors they could get *one* free copy of the book. I knew several of the authors and suggested we should drop Springer, self-publish and make the book available for free. This would be much more helpful for the tens of millions of psychiatric patients who want to come off their drugs but don't know how to do it, than to publish a very expensive book that few could afford to buy.

Some of my colleagues were sympathetic to this but dared not jump off, as they had signed a contract with Springer although this is not a problem. If authors don't deliver within the agreed time frame, the contract becomes annulled. They would not get paid anyhow, so why not give the book for free to the whole world? I fail to understand such people.

The project collapsed. We lost contact to Dunleavy who apologised after 3.5 years for his inactivity. In the meantime, people had lost interest in the book, and one of us, Mark Horowitz, published his own book about withdrawal.[1268]

I reluctantly accepted to write a chapter on psychosis for yet a third Springer book[1269] but only because Bob Whitaker had joined the project. I was kept in the dark and didn't even know what the other chapters were about before the book came out. It was 809 pages, in very small print, weighed 1.3 kg, and cost 187.49 Euros! Who would buy it and read all this? I uploaded my chapter so that people could read it for free.[1270] Not as published, which I was not allowed to do, but as what was accepted, which was the same.

About ten years ago, I was so fed up with the slave labour system in medical research that I wrote to the *BMJ* about it. I had done numerous peer reviews for *BMJ*, which were in the top 10% for their quality. I had also paid a lot to have my articles published open access. I told the editors that this was not fair and asked if they would let me publish for free for a while considering my huge contribution to the journal. To my big surprise, they agreed, and I published some articles for free.

**Predatory journals and conferences**

Over 15,000 journals are called predatory because they have no quality control and publish almost anything for a publication fee.[1271] In a way, all publishers are predatory because they charge far too much for their services and use slave labour, as I have just described.

I receive about 20 invitations per week to publish in predatory journals and two to participate in predatory conferences where people pay huge fees for listening to themselves. I reviewed the invitations to publish I received during March 2023.[1272] Most were written in very poor English and virtually everything is fake: the English sounding names of the senders, the impact factors, and owners, e.g. the Austin journals are not owned by a company in Texas but in India, and Nigeria and Pakistan are also often behind the fraud.

The invitations were full of flattery, with a sense of urgency. I was invited to attach my paper to the email with no author instructions and rapid publication was promised. The journals were often totally irrelevant for my research, e.g. *American Journal of Planetary and Space Science* and *Global Journal of Plant and Soil Sciences*. My preprint about methods for withdrawing depression drugs was of interest for *Journal of Clinical Microbiology and Antimicrobials*, and the preprint[1273] of my paper about predatory journals was wanted by *Journal of Pharmaceutical Sciences & Emerging Drugs*: "We have gone through your unpublished work entitled 'Review of invitations to publish in predatory scientific journals' and enthralled to know about your reputation and commitment. We strongly believe that this potential research would be beneficial to the people working in the field of Pharmaceutical Sciences."

I block all invitations, currently almost 2000, but they keep coming in at the same rate. One reason is that some spammers change their email address all the time. As an example, the Austin journals invited me with 37 different names after the @-sign, many of which differed by only one character. What came before the @-sign also varied, e.g. maria.joseph@, maria@, mariajoseph@, and maria-joseph@.

You cannot unsubscribe these irritating emails. If there is a link for it, it doesn't work, and if you write directly to the journal, they don't care.

You are often told that the journal desperate needs your help because they are short of articles for the next issue. Out of curiosity, I once asked:[1274] "Since you seem to have a problem, how much do you pay authors to help you?" Sylvia Rose from *Pharmacology & Clinical Research* replied that I was going to pay them, not the opposite, and, as it is customary for predatory journals, she did not tell me how much.

In 2020, two biologists published a nonsense study in Juniper's *Oceanography & Fisheries Open Access Journal*,[1275] which included the claim that barn swallows and flying fish are sister lineages. Predatory journals are big scale scientific pollution and fraud. The business model constitutes consumer fraud as it deceives many people who buy into something they don't get.

As the most meaningful titles have already been taken by reputable journals, titles for predatory journals are often a meaningless hodgepodge of words. I presented an analysis of the logical structure of some of the weirdest journal titles in invitations I received during January and February 2025.[1276] For example, *Journal of Nutrition and Health Sciences* could as well be *Journal of Diabetes and Everything Else*.

There is no clear divide between predatory journals and other journals. There are many journals in a greyzone, e.g. the *Future* journals, which I regard as predatory. The 300 *BMC* journals and *PLoS One* are also problematic. They have published thousands of poor papers for an open access fee, and in 2024 alone, PubMed listed 17,730 records for *PLoS One*.

# 11 Drug regulation is a tragedy

That drug regulation is seriously dysfunctional was recognised in a 2005 report from the House of Commons Health Committee in the UK. It noted that it is essential that the industry works in the public interest, which the regulatory system had failed to ensure.[1277]

An investigation by the US House of Representatives found "a growing laxity in FDA's surveillance and enforcement procedures, a dangerous decline in regulatory vigilance, and an obvious unwillingness to move forward even on claims from its own field offices."[1278] Its 2006 report documented a 54% decline in warning letters, and between 1999 and 2008, the FDA gave priority review status to almost 47% of new drug applications. The FDA leadership has shifted to talking about being a "partner" with industry to get more drugs to patients more quickly, which has had the result that the proportion of new products with serious harms has gone up from 1 in 5 to 1 in 3.

With less rigorous regulatory standards, more drugs than previously have been withdrawn from the market or have received serious safety warnings.[1279]

The FDA has approved many lethal and ineffective drugs; those at the top have often overruled their own scientists or advisory groups;[1280] and reports to the FDA of drug deaths have increased.[1281]

One reason why drug agencies don't function is the widespread corruption. This has been extensively documented for the FDA and has included people at the highest levels, including several commissioners.[1282] In 2009, nine FDA scientists wrote to President Obama in desperation.[1283] When five scientists had alerted the agency to safety problems to no avail and therefore had informed the politicians, FDA's response was to install spyware on their computers.[1284]

Bribery of top executives in drug agencies must be very tempting for drug companies. There is an enormous amount of money at stake and the approval of a new drug can be the difference between life and death for a company. In 2012, Lundbeck and its Japanese partner Takeda submitted vortioxetine, an SSRI, for regulatory approval in the USA.[1285] Lundbeck's blockbuster, escitalopram, was running out of patent, and the company would receive a $43 million milestone payment from Takeda if FDA approved this exceptionally poor drug (see page 133), which the FDA of course did.

Another problem is the revolving door phenomenon: People go back and forth between the industry and drug agencies. In Denmark, the person who helped Nycomed get approval for a slimming pill, Letigen ("light again"), went directly to a senior post in the company that owned the drug. Letigen contained ephedrine and was later taken off the market because of its cardiovascular harms.

There was uproar in the press when the Danish Drug Agency employed psychiatrist Bente Glenthøj in its registration committee.[1286] She had received millions from drug companies but couldn't see this was a problem. The Agency claimed it wasn't possible to get the expertise it needed unless it accepted conflicted people. However, as only 92 of 1201 registered psychiatrists had permission to work for a drug company, the agency dismissed 1109 psychiatrists as being unqualified. The Ministry of Health granted Glenthøj an exemption from the law provided she didn't participate in cases where doubt could be raised about her impartiality. What ingenuity. If she couldn't deal with cases where she was an expert, there was no argument for employing her!

The main purpose of drug regulation is to keep us safe, but if it worked, drugs would not be the leading cause of death.[1287] Oddly, I have experienced that people working in drug agencies cannot see that this is a problem.[1288]

Drug agencies issue countless warnings, precautions, and contraindications, although they know they don't work. The regulators assess drugs one by one and don't think it is their problem that doctors cannot possibly know about all the warnings. Every doctor knows that the anticoagulant warfarin can interact dangerously with other drugs and some food items, but doctors cannot even use this drug safely. About half of patients on warfarin are on other drugs that increase the risk of bleeding.[1289] Many patients are on multiple drugs, and doctors and regulators rarely have a clue about how they might interact in a harmful way.

We need to demedicalise our societies radically with the same reasoning that no one would dare to fly if the pilots' actions had unpredictable effects. I have estimated that drugs kill 882,000 Americans every year.[1290] Imagine if 4,410 airplanes with 200 passengers each crashed every year, which is 12 crashes per day – and the same death toll as for drugs. We don't even accept that a couple of airplanes of the same type crash every year. Then why have we accepted that so many patients are killed by drugs very few of them need?

In contrast to drug agencies and doctors, airline pilots are critically concerned with our safety because if we go down, they go down, too.[1291]

In 2016, we criticised the rapid decline in regulatory demands[1292] because the EMA had embraced a new model of drug testing and marketing called "adaptive pathways"- the brainchild of an industry funded think tank. The model allows the use of "real world data"- a euphemism for unreliable observational data - instead of randomised trials. EMA imagines that the uncertainty would progressively reduce as additional "confirmatory" data are collected in the post-marketing period. We argued, referring to solid science, why EMA's new fad would result in massive harm to patients.

Drug regulators have told me that the system builds on trust, which they think is fine, as it would have serious consequences for the companies if they cheated and it was detected. This argument is invalid. The industry knows that crime pays and therefore they have increased. Moreover, the authorities know that they cannot trust the industry. The reason they say the opposite is pragmatic. They cannot review more than a tiny fraction of the mountains of documents they receive.[1293]

Drug regulators are so sloppy that they don't even check that everything is included. I have found many examples that whole appendices, many pages in the middle of a report, cases of suicidality, or negative trials were missing in the documentation of depression drugs submitted to European drug regulators for marketing approval,[1294] even violating the law. In 2022, my research group demonstrated that some trials of extended-release methylphenidate (Ritalin) were missing in 7 of 13 applications to drug agencies, and that the median proportion of missing trial participants was 45%.[1295]

Drug regulators may also destroy the data they have. The UK drug regulator informed us that all application files and data for licenses are destroyed after 15 years, "unless there is a legal, regulatory, or business need to keep them, or unless they are considered to be of lasting historic interest."[1296] I believe there are always legal and historic interests, as industry trials are often flawed and sometimes fraudulent.

It was particularly scandalous when the FDA approved rofecoxib (Vioxx) because it lacked "complete certainty" that the drug increased cardiovascular risk, although this was expected based on the drug's mode of action.[1297] Imagine if a doctor prescribes a drug for a patient

saying: “I’m not completely sure this drug will kill you, so please try it.” In a cartoon, a doctor says: “Take one of these tablets tonight, Mr Tate, and one more if you wake up tomorrow morning.”

In 2007, I lectured for upcoming specialists in internal medicine in clinical decision theory and asked them what they would do if they didn’t know how to treat a patient. Some said that if there had been an article in *New England Journal of Medicine*, they would trust it.

I then told them about the Vioxx scandal. The *NEJM* editors did not react to the fact that heart attacks were missing in the fraudulent VIGOR trial on rofecoxib they had published.[1298] Pharmacist Jennifer Hrachovec sent a letter to the journal pointing out that there were three more heart attacks on rofecoxib on FDA’s website than in the journal article, which the editor rejected because of “lack of space.” This is editorial misconduct. A year later, Hrachovec called a radio show on which the editor, Jeffrey Drazen, appeared and begged him to correct the paper, but Drazen responded evasively.

It would have looked very different if the three heart attacks had not been deliberately omitted from the trial report, and there were other editorial blunders. The editors didn’t ensure that thromboses were appropriately described and discussed. There were two full tables of gastrointestinal adverse effects in the article, but no table of thromboses. They were only mentioned in a few lines in the text, and only as percentages, which made it impossible to calculate the exact number of events, as not all of them were included. But I tried. Based on the percentages, I calculated 32 and 17 thrombotic events on rofecoxib and naproxen, respectively, but there were actually another 15 versus 3 events.

That wasn’t even all. The FDA reviewer found a death from a heart attack on rofecoxib that was coded as something else. The Merck scientist who had judged that the patient died from a heart attack was overruled by his boss, “so that we don’t raise concerns.” The cause of death was called unknown in Merck’s report to the FDA. Conversely, there were two deaths too many on naproxen, and many more events disappeared on rofecoxib than on naproxen in the published report.

The editors allowed Merck to say that the reason rofecoxib caused more thromboses than naproxen was that naproxen was protective rather than rofecoxib being harmful. This nonsense was wholly speculative and later refuted, and it was irrelevant. As there were more serious events with rofecoxib, naproxen was the better drug.

When the editors could no longer hide the scandal, they noted that forensic IT work on the submitted disc revealed that the three cases of myocardial infarction had been omitted from the manuscript two days before it was submitted to the journal. They also found out that Merck had selected an earlier cut-off date shortly before the trial ended for the thrombotic events than the cut-off date for the gastrointestinal events, which they were not informed about. This was also fraud.

The *NEJM* editors put the blame on Merck and the clinical investigators but forgot to mention their own role in allowing the obviously flawed paper to appear in print.

After five years of silence, in 2005, when the drug had been withdrawn and the journal ran a risk of getting accused in court cases, the editors finally reacted by publishing an “expression of concern.”[1299] If they had acted earlier, it might have killed the sales of Vioxx instead of killing the patients. *NEJM* sold almost a million reprints of the article which must have brought in many millions of dollars. I have estimated that Merck killed over 100,000 patients with Vioxx because of its fraud in research and marketing.[1300]

The fraudulent trial was never retracted. *NEJM* does not deserve the prestige it has.

When I saw a TV commercial in the USA on CNN in 2006 that ended with a very deep voice saying, "Merck, where the patients come first." I couldn't help thinking, "Merck, where the patients die first."

There are numerous examples that *NEJM* have published serious flawed industry trials, and I have commented on some of them.[1301] These trials are not science but an advertisement for the drugs. I told the course participants about a couple of other cases where *NEJM* had behaved irresponsibly and had refused to publish letters that would have alerted their readers to fraud in drug trials.

I was met with hostile reactions. *NEJM* was their sacred cow. How dared I criticise the holy grail of medical journals, the very journal that all researchers hope to get into. Of the general medical journals, this journal had the highest impact factor.

In documents for a 2005 FDA hearing, Pfizer denied that its NSAID celecoxib (Celebrex) causes heart attacks, even though the company had unpublished evidence to the contrary.[1302]

Pharmacia, later bought by Pfizer, published a large fraudulent trial, the CLASS trial, in *JAMA* in 2000. The advantage of celecoxib over two old drugs disappeared when the protocol-specified analyses were performed by independent researchers. The company had conducted at least 34 subgroup analyses that were not prespecified. The fraud, which was propagated in many meta-analyses, must have been worth billions of dollars for Pfizer.

Pfizer threatened a Danish physician, Preben Holme Jørgensen, with litigation after he had stated correctly in an interview that it was dishonest and unethical that the company had published only some of the data from the CLASS trial.[1303]

A meta-analysis conducted by independent researchers using FDA data showed in 2006 that celecoxib doubles the number of heart attacks compared with placebo. I calculated that, up to 2004, celecoxib had caused 75,000 deaths because of thromboses. But the drug is still on the market.

Pfizer had ads in our medical journal showing an elderly lady dancing on a table with the text: *Life is too long to have pain*. I reproduced the ad and added: "and too short to die of myocardial infarction."[1304]

The Danish Drug Agency is very beholden to the drug industry. It changed the product information into: Clinical studies *suggest* that selective COX-2 inhibitors *may be associated* with a *risk* of thromboembolic events. An honest information would have been: Clinical studies *have shown* that selective COX-2 inhibitors *increase* thromboembolic events.

The *NEJM* editors were complicit in the fraud and the killings in other ways. For example, the two authors of a 2001 dreadfully long review article in *NEJM* had financial ties to the makers of Vioxx and Celebrex and their paper was a shameful advertisement for the drugs.[1305] They mentioned a non-existing advantage of Celebrex that the FDA had forbidden the company to mention, and they dismissed the serious harms of the drugs in a most unacademic fashion.

NSAIDs also kills by causing stomach ulcers. It was estimated in 1999 that NSAIDs killed over 16,000 Americans this way, roughly the same number as those who died from AIDS.[1306]

Most of those who died could have had a good life without NSAIDs, but the drug industry lured doctors into using NSAIDs for virtually every kind of pain, assisted by corrupt rheumatologists and pain specialists. A journalist writing about Vioxx and Celebrex called a society of US rheumatologists in 2000, wanting to speak to an expert who wasn't being paid by either company. She was told there was none.[1307]

When an independent Spanish drug bulletin wrote that the so-called advantages of the two drugs were scientific fraud, Merck sued the author, Joan-Ramon Laporte.[1308]

Even after it was widely known that their drugs increase heart attacks, some companies deceived patients they invited to participate in their trials.[1309] In 2009, the information Pfizer gave to participants in a large trial comparing celecoxib with other arthritis drugs said it was unclear if celecoxib increased the risk of heart disease and stroke, but four years earlier, the package insert mentioned the cardiovascular risks and Pfizer had also written to doctors advising them that celecoxib increases cardiovascular risks.

GlaxoSmithKline behaved similarly badly. In 2009, they started a large trial comparing the "cardiovascular safety" of two diabetes drugs, rosiglitazone and pioglitazone, although the company had long known that rosiglitazone increases the risk of heart attacks compared with pioglitazone, but this risk wasn't mentioned in the information to patients.

Six months before Merck withdrew Vioxx, it stated that "MSD is fully committed to the highest standards of scientific integrity, ethics, and protection of patient's wellbeing in our research. We have a tradition of partnership with leaders in the academic research community."[1310] I wrote in my book about organised crime in the drug industry that perhaps Hells Angels should consider something similar in their PR: "We are fully committed to the highest standards of integrity, ethics and protection of citizens' well-being when we push narcotic drugs. We have a tradition of partnership with leaders in the police force."

It's a gross failure in drug regulation that drugs with known harms are approved without adequate safety data and the COX-2 inhibitors are a perfect example. We knew beforehand that their mechanism of action predicted an increased risk of cardiovascular mortality.

When I discussed this with a drug regulator, Steffen Thirstrup, he replied that if they were to demand such data, it would delay the introduction of valuable drugs for years. So what? That would mean huge progress for the patients. When Thirstrup left the drug agency, he started working for NDA Regulatory Service, a company that helps drug companies with getting their products on the market. Today, he is the medical director at EMA. The revolving door in full swing.

Thirstrup's argument is invalid. A drug company could easily have performed a trial of its COX-2 inhibitor that could have told us what the harms are, particularly if choosing a relevant patient population. The number needed to treat for one year to cause one extra heart attack on such a drug is only 70 patients.[1311]

Moreover, the fundamental ethical issue - avoiding killing patients in large numbers - cannot be trumped by petty claims about practicalities and potential loss of income.

In 2018, Karsten Juhl Jørgensen and I published the article, *Does the drug agency work for the patients?*[1312] Several people in leading positions in the Danish Drug Agency had worked in the drug industry within the last five years, had shares in the industry, or both, including its director, Thomas Senderovitz. In Norway, Sweden and EMA, such conflicts were not accepted, among other reasons to reduce the risk of insider trading. Four of five leaders working with surveillance of drug harms had conflicts of interest. We asked if such conflicts related to the tobacco industry for a director employed at the Board of Health to survey tobacco related harms were acceptable.

This created some debate and a year later, it was decided that employees at the drug agency could no longer hold shares in the industry they regulated.[1313]

We also mentioned that the drug agency had failed in relation to tramadol, an opiate sold by Grünenthal. In 2017, an ad in our medical journal touted: "Finally, a highly effective

pain reliever with a low risk of dependence."[1314] Two months earlier, a TV documentary had shown how corrupt the pain field is.[1315] Grünenthal was everywhere, supporting meetings, doctors, patient organisations and even the production of guidelines about how to treat pain. Senderovitz had worked at Grünenthal, which fiercely denied in the 1960s that its drug thalidomide could cause birth defects.

In the documentary, the drug agency was asked which studies had caused it to accept Grünenthal's claim that tramadol was "minimally addictive." The agency handed over eight studies which were scrutinised by three experts, including Karsten. They all concluded that none of the studies provided evidence that the patients rarely become addicted.

Confronted with this, the drug agency said they based their judgment on other data, too. When the agency was asked to provide these data, it turned out that there were no data in support of the statements of the agency, which starred as the industry's useful idiots.

Grünenthal launched a successor to tramadol - tapentadol - 20 times more expensive, again claiming that addiction was nothing to worry about, with no evidence in support of this preposterous claim, which the same three experts confirmed.

But remember: An authority can never be wrong. So, the drug agency did nothing to help the 300,000 Danes (5% of the population) who took tramadol and to rectify its own faults, did not apologise or admit its wrongdoing, and did not change its lie that the risk of dependence is low.[1316] It put the blame on the doctors by sharpening their reporting obligation when they saw cases of dependence. A cowardly fake fix.

They also did everything they could to shoot the messengers. Seven days after our article about the agency, Senderovitz and Nicolai Brun, medical director at the agency, launched a brutal counter-attack, in the same newspaper, with the long and declarative headline, *Peter Gøtzsche and the Nordic Cochrane Centre are becoming more and more shrill in the debate. What about spending your public support money on research?*[1317] They wrote: "You can ask yourself if you are getting as much out of the Nordic Cochrane Centre as you should. Since the centre is financed by significant tax money, one should expect that the centre and its management deliver very high-quality research that benefits the Danish society and raises the level of the health debate."

A retired chief physician, Peer Tfelt-Hansen, noted that it was a strong accusation that we did not fulfil our research obligations but wrote "endless debate articles."[1318] He found it noteworthy that the drug agency had not documented their claims. He found that, impressively, from 2008 to 2017, we had 41 publications related to Cochrane reviews and 120 reviews and systematic reviews in international journals, with no decrease in recent years.

Senderovitz and Brun tried to avoid discussing the issues we had raised by discussing something else, and they lied brutally also when they claimed that we did not produce high-quality meta-analyses. We were highly respected everywhere in the Danish society, all the way up to the Minister of Health for exactly those qualities they said we didn't have. In his book, *The art of always being right*, philosopher Arthur Schopenhauer calls this deplorable trick "Postulate what has to be proven."[1319]

They referred to my article about Rasmus Burchard's tragic suicide[1320] (see page 139) and said I drew non-evidence-based conclusions based on a single patient case. This was also a lie. I wrote that all depression pills should be taken off the market because doctors are unable to handle them in such a way that they do more good than harm. This is an evidence-based conclusion.

They claimed my centre had lost its influence in professional circles and that we had "little or no insight" in the areas we spoke about. This is about as far from the truth as one

can come, but truth was immaterial for Senderovitz and Brun. They behaved exactly as if they were still employed in one of the criminal drug companies they came from. "It does no one any good for the debate to be conducted in such a conflicted manner," they wrote. So, when there is nothing wrong with our arguments, it must be the "tone," the way we present them, that is wrong. And we were not conflicted, as they claimed, the agency was. When Karsten was interviewed on TV about tramadol, he was excellent, low-key and diplomatic.

This affair is significant. The article shooting the messengers was written by the top at our drug agency who undermined its authority totally. Jens Ersbøll, previous chief physician at the agency, wrote to us that he found that the article was a very aggressive, almost perfidious personal attack on me, far below the minimum for a professional government agency. And when the agency complained that we raised the same debate repeatedly, it was their own fault because they never responded adequately to criticism.

Sadly, authority wins, even when it is mendacious, and the mean attacks on me intensified on social media. People argued that we should be stripped of our public funding, and Senderovitz sank to the ethical bottom when he accused me of being an anti-vaxxer because I was going to speak about the HPV vaccines in Dublin. He showed the programme on Twitter. My talk was: "Complaint to the European Ombudsman and maladministration at EMA" (see page 111). Strangely, when Senderovitz was a medical student, he worked for me when I was the daily leader of the AIDS trials financed by the Nordic Medical Research Councils. Back then, he did not display the character deficiency that was so obvious in 2018.

Member of Parliament Stinus Lindgren wrote on Twitter that many important points were made in the article about my centre; journalist Lars Igum Rasmussen, who had written many fine articles about me in *Politiken*, suddenly showed his Judas face and echoed that we had become more and more shrill in the debate and should use our public funds on research. We were even accused of being conspiratory rather than evidence-based.

Like drug agencies, editors of prestigious medical journals do not admit their mistakes either. In 1980, two people from the Boston Collaborative Drug Surveillance Program published a very harmful letter in *New England Journal of Medicine* with a declarative title: *Addiction rare in patients treated with narcotics*.[1321] There were only five sentences in the letter:

"We examined our current files ... Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well-documented addiction ... We conclude that … the development of addiction is rare."

On the journal's website, a note from the editor was published 37 years later: "For reasons of public health, readers should be aware that this letter has been 'heavily and uncritically cited' as evidence that addiction is rare with opioid therapy."

A former editor of *Anesthesia & Analgesia* called for an apology from the letter authors and the editors who should be deeply ashamed to have published such data without adequate scientific documentation, which had led to incredible damage, including destroyed lives and communities, and thousands of deaths.[1322]

The editors did not apologise but put the blame elsewhere. The problem was how the letter had been used by others! Canadian researchers noted that the letter had been cited 608 times, which had contributed to the North American opioid crisis by helping to shape a false narrative that opioids are not addictive.[1323]

We had seen this before. OxyContin was aggressively marketed with fraudulent claims about not causing addiction. In just 16 years, close to 200,000 deaths from prescription opioids were reported in the USA, and millions of Americans became addicted.[1324] In 2007,

the manufacturer of OxyContin and three senior executives pleaded guilty to federal criminal charges that they had lied to regulators, doctors, and patients. The drug became a leading drug of abuse under the nickname “hillbilly heroin,” and in Denmark, OxyContin was so aggressively pushed that it was necessary for the drug committee at my hospital to ban the drug altogether, so that clinicians could no longer order it from the pharmacy.

In 2018, I published the article, *Patients not patents*, where I documented that our current system for drug innovation, approval and usage has failed public health miserably.[1325] Companies set prices as they want; some people die because they cannot afford to buy the drugs they need; and the system is inefficient because knowledge about toxicity and failed projects is not shared.

I proposed an alternative where the drive for profit maximisation is replaced by a non-profit public interest driven system. As most breakthroughs come from publicly funded research, this system would result in dramatically lower costs for society and the patients, and by selling drugs at low prices even third world countries could afford to buy them.

Once fully implemented, patenting of drugs and devices, regulations impeding the introduction of generic drugs and biosimilars to the market, and international trade agreements emphasising secrecy and commercial confidentiality would be gone.

In the transitional period towards public drug development, compulsory licensing and government use of patents could ensure the availability of essential drugs. These methods are allowed under international law but are much underused.

To engage the public in the profound changes that are needed, a programme of myth busting should be undertaken to combat the widespread erroneous beliefs that sustain the current system. These programmes could also raise public awareness about the enormous inefficiencies that make the current system financially and morally unsustainable.

Politicians often see the drug industry as a growth factor contributing to jobs, trade balance, and the knowledge economy - a perception the industry promotes. Many people in the drug industry have invaluable expertise but they might prefer to use it in a non-profit environment.

Psychological research has shown that inventing or contributing to something that is genuinely helpful to people can be a very strong motivator, much stronger than money.[1326] Therefore, no lack of incentives will exist for helpful innovations. In fact, it seems that the high-risk, bold investments that led to technological revolutions in the past were sparked by public sector institutions.

In contrast, there is very little innovation in the drug industry. Since 1981, the independent journal *Prescrire* has granted Pilule d’Or (The Golden Pill) to drugs that constitute a major therapeutic advance in a field in which no treatment was previously available. There was no worthy candidate in 24 of the 34 years spanning from 1982 to 2015.[1327]

Drug agencies would be publicly funded and focused on drug harms, and they would have a well-funded department - completely separate from the department that approves drugs - that allows independent decisions to be made about drug withdrawal for safety reasons.

Trials would be large enough, and would run for sufficient lengths of time, to capture rare and lethal harms, and they must show a clinically relevant effect by meeting pre-defined criteria. Drugs would no longer be approved based on surrogate outcomes (e.g. blood glucose rather than complications to diabetes). We do not approve cars based on the fact

that we can start the engine. But for drugs, which kill 20 times more people in the USA than cars do, we don't care that we have not requested adequate safety data.

If I turned up next time at the biennial car inspection without my car but with 10 m of paper and told the inspectors they should examine the enormous pile of paper where all the results of my careful testing of my car were reported, they would think I was crazy. Isn't it then crazy that we have accepted a system where this is what the drug industry does? The big difference is that if my car's brakes fail, I might kill myself and a few others, whereas if a company hides lethal harms of its drug, it might kill tens of thousands of people. We should therefore be much more cautious about drugs than about cars, but we aren't.

All clinical trials of drugs and devices would be performed by non-profit institutions, and no one would have conflicts of interest related to drug companies. Additional safeguards, such as blinding data analysis and writing of manuscripts, would be put in place.[1328]

Publicly conducted drug trials would ensure that new drugs are being compared with old, cheap drugs under fair circumstances and with non-drug interventions. To improve the usefulness of trials, draft protocols would be publicly available allowing patients and others to comment on them.

All data would be publicly accessible, including the raw, anonymised patient data, allowing others to conduct their own analyses. The trial reports would be published in open access journals or on the web allowing everyone, including patients volunteering for the trials, to access them free of charge. Preclinical studies, e.g. animal toxicology studies, including the raw data, would also be made available.

# 12 Vaccines: more complicated than you think

People who had read my book about organised crime in the drug industry sometimes asked me why I had not discussed vaccines. Well, none of the biggest crimes had involved vaccines and they are some of the most fantastic drugs we have. The WHO has estimated that they prevent 2-3 million deaths every year, and that a further 1.5 million deaths could be avoided if global coverage of vaccination was improved.[1329] Vaccines have eradicated smallpox, which has a mortality rate of about 30% and is estimated to have killed 500 million people in the last 100 years of its existence.[1330] I have been vaccinated many times but not against influenza, as I knew the vaccine is not particularly effective and that my risk of getting influenza is very low.

It was an eye-opener when I found out that the regulatory requirements for vaccines are much weaker than those for drugs. Very few trials include an untreated control group, which can make it impossible to ever know what the harms are because the vaccine adjuvant or the vaccine used in the control group might cause similar harms as the vaccine.

There is a lot we don't know about vaccines and, as for other drugs, many vaccine harms are never recorded or have been omitted from the published vaccine trial reports.

I know two of the most outstanding vaccine researchers in the world, professors Peter Aaby and Christine Stabell Benn from Copenhagen. I met Peter in 1988 at a course in epidemiology in Göteborg where I helped him with a statistical problem. He wanted to test if the risk of dying from measles increased with the number of people in the household in an archival material, he had from Copenhagen that was almost 100 years old. I worked out a test for him, which showed he was correct. The more crowded people live, the greater the risk of dying. He also showed this in Africa. And he debunked the myth that the children die because they are malnourished, which unfortunately is still what the WHO claims.

Peter and Christine's most important findings are that live attenuated vaccines decrease mortality more than predicted from their specific effect while non-live vaccines increase total mortality.[1331] They have also shown that the sequence of vaccinations is important; that it is best to end with a live vaccine; and that the harms of non-live vaccines predominantly affect girls. Peter's vaccine research is so ground-breaking that it is on the list of milestones in *Nature*,[1332] which starts with the discovery of the smallpox vaccine.

In July 2022, Christine uploaded a video with Peter on YouTube about his research in Africa. The video is mostly about the hugely beneficial non-specific effects of the measles vaccine. But Peter also mentions his interactions with the WHO related to the introduction of a high-titre measles vaccine, which he showed increased mortality in girls. Initially, the WHO did not react, but when American colleagues confirmed Aaby's findings in Haiti, the high-titre vaccine was withdrawn. This decision is estimated to have saved around 0.5 million lives per year in Africa alone.

Peter later found out that the increased mortality in girls was only seen when they had received a DTP vaccine (see below), a non-live vaccine, after the measles vaccine.[1333]

Christine discovered that YouTube had removed the video very quickly due to "inappropriate content." She appealed and received a robotic message the next day claiming that they had carefully reviewed the content.

When she wrote about her frustrations on Twitter and LinkedIn, she was contacted by Danish TV2 that wanted to write an article about it. As Google owns YouTube, they contacted Google's director in Denmark, Jesper Vangkilde. He said it was a mistake to remove

the video, which was uploaded again. Christine asked Vangkilde why YouTube removed the video, rejected her appeal, and changed their mind again? She got no reply.

According to YouTube's guidelines, it is not possible to overturn a rejected appeal. But if people have a "big megaphone" on social media, as Christine said, it can be done. TV 2 asked similar questions, but Google provided a standard reply indicating that they do not consider appeals at all but just reject them. Christine said to TV2 that Google's censorship is toxic because it increases the distrust in the authorities and vaccine hesitancy.[1334]

In 2023, I interviewed Christine about vaccines for our *Broken Medical Science* film channel (see page 419).[1335] We discussed non-specific beneficial and harmful effects of vaccines and why the COVID-19 vaccines were overused, e.g. to children. On a Sunday, in March 2024, my filmmaker tested YouTube's censorship by uploading the interview. It took YouTube less than an hour to remove it: "Our team has reviewed your content, and, unfortunately, we think it violates our medical misinformation policy."

We appealed and YouTube's robot replied: "We reviewed your content carefully and have confirmed that it violates our medical misinformation policy." It took YouTube less than an hour to evaluate the video carefully, which is impressive, as it lasts 54 minutes.

The video had been online on our own website for six months. We wondered why social media wanted to prevent scientific debate about the benefits and harms of vaccines. Censorship creates distrust in science more generally, and as politicians operate in the public sphere, scientists should be allowed to do so, too. We don't want social media to direct us to an Orwellian Ministry of Truth, which are the websites of governments, the WHO, or the US Centers for Disease Control and Prevention. The aim of censorship is to reduce misinformation but ironically, it increases it because those scientists that do not keep quiet will, for fear of harassment, tend to say what falls in line with current government policy.

We know very little about what happens when we use many vaccines and what their long-term effects are on the immune system. We need large, publicly funded trials with long follow-up that allows registration of late-occurring benefits and harms. They could be simple, pragmatic, and cheap, and they could be very cost-effective, as we would likely find out that some vaccines or combinations are harmful while others are beneficial. Alas, it is difficult to get support for such simple ideas. The vaccine area is characterised by dogma, and people in leading positions in healthcare know what is expected of them. You don't get popular with politicians by raising questions about vaccines.

The childhood vaccination programmes differ markedly from country to country. When I looked this up, 17 vaccines were recommended in the USA and only 10 in Denmark. Sometimes, five vaccines are given simultaneously, even though we don't know what the net effect of this is, and even though none of them contain live attenuated microorganisms.

Vaccine programmes have not taken Aaby's findings into account. Since vaccinations can weaken the immune system and some vaccines increase total mortality, it is reasonable to ask if the many childhood vaccinations could result in net harm. I am aware of only two researchers who have studied this.[1336] They did several studies and found that nations that require more vaccines for their infants have higher mortality rates in small children. This is alarming and should lead to other studies as a matter of urgency.

I published a book about vaccines in 2020, which I updated in 2021.[1337] It came out in seven languages and is thoroughly evidence-based. I was therefore puzzled that the reviews of my

translation of the book into Danish were very negative and that I was attacked in a most unacademic fashion. I had stepped into a minefield once again.

Virus professor Jens Lundgren said I am controversial and have strong views on breast cancer screening, psychiatric drugs, HPV and influenza vaccines, transparency in the pharmaceutical industry's reporting and the medical profession's mixing of interests.[1338] How can it be wrong to study the science carefully and conclude accordingly? Lundgren collaborates closely with drug companies, and his undeserved praise of the ineffective drug remdesivir against COVID-19 is noteworthy (see page 450). He has also praised Tamiflu for influenza even though it doesn't work either (see page 293).

Physician Ida Donkin started her book review saying,[1339] "The name Peter C. Gøtzsche is familiar to most people. A highly regarded doctor who took the trip from the top of the mountain of credibility as co-founder of the evidence-based Cochrane Collaboration and head of the Nordic Cochrane Centre, and who ended up being expelled in full public view." This is mean. I was expelled because I am trustworthy, which went against Cochrane's interests. My credibility is intact, but Cochrane's isn't (see page 411). According to Donkin, I am on a crusade. The first sentence in my book is: "This book will help you navigate in the bewildering, and often contradictory, flood of information about vaccines." Is it a crusade to inform people? She called it "conspiracy theories" that I have proven that conflicts of interest influence medical recommendations, and the rest of her review is full of similarly primitive attempts at character assassination.

My vaccine book sells very little in the USA, even though a major US company published it. This is because it is factual. What people want to hear are false messages, and totally untruthful "antivaxxer" books are sold to millions of people.[1340] Charlatans, which include doctors, make fortunes by propagating deadly misinformation while describing themselves as being holistic. After having challenged some of them to explain what they mean by this, I realised it is a euphemism for saying: "I don't know what I am doing but I am surely making a hell of a lot of money by fooling people into buying my useless supplements."

To sustain their wrong beliefs, these quacks cherry-pick observations in their support and disregard those to the contrary. Looking for confirmation of your beliefs is unscientific and risky. A duck may get its belief that human beings are very nice to it reaffirmed every day until the day comes when it will be slaughtered and eaten - quack, quack.

In my book, I tell people that we must evaluate carefully each vaccine, one by one, assess the balance between its benefits and harms, as we do for other drugs, and take the disease prevalence into account, as this is important for decision making.

For polio, there is no doubt. The vaccines are one of the greatest triumphs of healthcare research. One in 200 infections leads to irreversible paralysis and 5-10% of those affected will die.[1341] There is a non-live injected vaccine and a cheaper, oral attenuated vaccine, which many people have taken on a piece of sugar. The attenuated vaccine causes a few outbreaks every year, caused by vaccine remnants that have spread in the environment, mutated, and regained their ability to paralyse unvaccinated children. However, the live polio vaccine has saved a huge number of lives, and, like the measles vaccine, it seems to have strong non-specific effects, decreasing mortality from other infections, too.

For Japanese encephalitis, I worked out that one should not normally be vaccinated, even when visiting endemic areas. The risk of getting it as a traveller is very small, and although about 25% of infected persons die, the vaccine can be deadly, too.

As I shall explain, authoritative advice about vaccines is not always trustworthy, and I have mixed feelings about the WHO. There have been too many issues with conflicts of

interest and of bending the evidence to comply with political wishes, and too many unfortunate announcements and recommendations, e.g., the declaration of a flu pandemic in 2009 that proved to be milder than other influenza epidemics, and the associated stockpiling of Tamiflu (see page 293). WHO's new criteria for vaccine harms from 2013 are horrible,[1342] as they make it virtually impossible to ever conclude that a vaccine causes a suspected harm.[1343] Both papers make for chilling reading.

My main worry about authorities is that citizens might decide to reject all vaccines when they find out they have been fooled in relation to a particular one where they were already in doubt. Another issue is self-censorship among top scientists when they experience that their worries about vaccine harms lead to hostile public reactions and smear campaigns.

## HPV

What really sparked my interest in vaccines were the HPV vaccines intended to prevent cervical cancer deaths by reducing the risk of getting infected with the human papillomavirus.

Helle, my wife, and I had not perceived vaccines to be a problem before we in 2008 got a letter from a doctor upon our oldest daughter's 12th birthday, asking us to enrol her in an HPV vaccine trial conducted by GlaxoSmithKline. I asked for the trial protocol,[1344] which had no information about harms, only some industry mantras like "generally safe and well-tolerated." As the information to parents noted that the vaccine had "affected the nervous system, blood cells, the thyroid and the kidneys," we wanted to know what that meant and how common these harms were.

The protocol referred to an *Investigator's Brochure* in relation to adverse events, which I asked my colleague to send, too. I also warned him that the protocol stipulated that GSK owned the data and that the investigators would not be allowed to publish anything without the company's permission. I urged him to ask GSK to confirm that the results would be come out regardless of what they showed. He responded he could not send me the *Investigator's Brochure* but did not explain why. We therefore did not enrol our daughter in the trial.

Helle vaccinated her, but we were in doubt. Thousands of reports had been submitted to the authorities of adverse effects including nausea, paralysis and death, and many people were worried,[1345] even though we cannot know if the events were caused by the vaccines.

Seven years later, a heated debate about the vaccines started. In March 2015, Danish TV2 showed a documentary about girls who felt the system had treated them very badly when they complained about serious harms they had experienced.[1346] The documentary was very good, and it stated that no one knew with certainty if the symptoms were caused by the vaccine. Nonetheless, the authorities and interest organisations like the Danish Cancer Society raised a storm of protests, which had the effect that the TV station never dared touch this subject again. The two key journalists visited me and I encouraged them to continue, but they couldn't, even though they found out via the Freedom of Information Act that the Board of Health had failed to communicate warnings about the vaccine. A Master of Public Health experienced that the Danish Cancer Society censored her Facebook page, where she had criticised the vaccine, so that she could no longer upload comments.

Research carried out by Louise Brinth at the Syncope Centre in Copenhagen confirmed that some of girls might have been seriously harmed by the vaccines.[1347] The possible harms included postural orthostatic tachycardia syndrome (POTS), complex regional pain syndrome (CRPS) and chronic fatigue syndrome (CFS). It is likely that serious neurological harms can be

caused by an autoimmune reaction where the body produces antibodies against its nervous tissue,[1348] and in 2022, the Syncope Centre reported that, after vaccination, autoantibodies were found in most girls with POTS combined with other symptoms of dysautonomia, but only in a minority of vaccinated girls who were healthy.[1349]

Some psychiatrists suggested the girls just suffered from psychiatric problems. I didn't buy that explanation. When I was a child, women with menstrual cramps were called hysteric (*hysteros* in Greek means womb), but that changed when it was shown that prostaglandins cause the pain and that prostaglandin synthetase inhibitors reduce the pain.

Because of Louise's findings, the Board of Health arranged a meeting in August 2015. I did not have any interest in vaccines, but a previous Head of Cabinet in the ministry, Ib Valsborg, urged me to attend, hoping I would become convinced there was nothing to worry about. There surely was. Louise said that many of the affected girls were elite sportswomen, which made sense to me because such people have a weakened immune system.

The Danish findings led to a request from the Danish government, which caused the European Medicines Agency (EMA) to study the harms. In November 2015, EMA issued a report stating that the benefits of the vaccines outweighed their harms and that "the case series" reported by Brinth and colleagues was "a highly selected sample of patients, apparently chosen to fit a pre-specified hypothesis of vaccine-induced injury."[1350]

This arrogant statement was defamatory and wrong. EMA also claimed that there was no objective clinical evaluation in Louise's studies, but the orthostatic intolerance was quantified through tilt-testing, which is the benchmark test for POTS. It was also highly troubling that when EMA asked Merck to find cases of POTS in its safety database, Merck came up with 83 cases but reported that only 33 cases fully met the criteria for this diagnosis,[1351] which EMA accepted. This worldwide number of Merck cases was clearly incorrect and grossly misleading.[1352] Of the 83 cases, 41 were from Denmark, and most of these, perhaps even all, had been diagnosed by Louise.

Incompetent journalists were very aggressive toward Louise and triumphantly touted the case was settled. The headline in *Politiken* was: *Danish researchers knocked down: No correlation between HPV vaccine and severe symptoms. The European Medicines Agency strongly criticises Danish researchers' methods*."[1353] This article ignited a witch-hunt,[1354] although Louise had only done her duty, to report her observations.

There was nothing wrong with Louise's methods or reporting, but Leif Vestergaard, director of the Danish Cancer Society, joined the witch-hunt. He didn't deny the journalist's suggestion that her research bordered on scientific misconduct and even called upon the Board of Health to investigate if the Syncope Centre had the right staff. This is typical of Orwellian states: "We remove critical voices but won't say so directly; we ask the Ministry of Truth to intervene."

Big Brother is watching you. A journalist working on a story about a girl who quit school after experiencing serious harms of the HPV vaccine was contacted by Mads Damkjær from Sanofi Pasteur MSD before the story was printed. Damkjær tried to convince him that the girl was unreliable. All doctors declined to be interviewed. They were afraid of Sanofi.[1355]

Another journalist contacted the Board of Health to get an interview about the possible harms of the HPV vaccine, but the next day she was contacted by a woman from a PR agency working for Sanofi who said she knew what the journalist was working on. She consistently described side effects as "rumours" or "myths" that came from America's anti-vaccine lobby.

When the journalist published her article, Damkjær complained to the editor that she was a "horny frontpage-seeking impossible person" who "reads numbers and facts like Satan

reads the Bible," and he added that Danish media were so pressured that one could feed pigs with unemployed journalists, and that a catastrophe like her did not have diligence, fairness, or source criticism among her virtues.[1356]

The journalist noted that doctors who had communicated their concerns to the authorities were unwilling to be interviewed for fear of damaging their relationship with the industry and of being associated with anti-vaccine radicalised "idiots."

Few researchers would be willing to communicate their suspicions about possible harms of vaccines or other drugs if they knew they might risk such harassment and humiliation. Louise suffered tremendously, and her children were even harassed at school. It was like the Catholic Inquisition.

In 2016, I, Louise and three others accused EMA of maladministration,[1357] as they had not assessed the possible serious neurological harms of the vaccines appropriately. EMA's reply was disappointing. Some of our concerns were not addressed and several statements were incorrect, misleading or irrelevant. We therefore complained to the European Ombudsman, but her reply was also disappointing. No one wanted to get near the hot potato.

Our criticism was substantial and warranted:

EMA had let the manufacturers, Merck and GlaxoSmithKline, to do the work for them even though these companies engaged in organised crime. EMA asked them to search for possible harms in their databases and did not react to the fact that the search strategies were grossly insufficient and must have overlooked many cases.[1358] The companies did not search for *headache* even though all Louise's patients had headaches, and *dizziness* needed to occur together with *orthostatic intolerance* or *orthostatic heart rate response increased* to count. Worst of all, EMA knew it could not trust the companies. The Danish authorities had noted that only 3 of 26 registered reports of POTS showed up in Sanofi's searches, and Sanofi had been criticised by EMA's own trial inspectors. It was also known that the complaints of three Danish women who experienced serious adverse events after Gardasil in a trial were never registered. In numerous other cases, the harms disappeared. This was fraud.

A colleague provided us with a confidential copy of an EMA expert report for Gardasil 9, which showed that Merck had deliberately avoided identifying possible cases of serious neurological harms of the vaccine.[1359] It was particularly damning that three people who had been diagnosed with POTS in the clinical safety database after receipt of Gardasil 9 were not reported as adverse events; that a case of POTS after Gardasil was not an adverse event but was called "new medical history;" that hospitalisation for severe dizziness was not reported as a serious adverse event; and that for another person the term "dysautonomia" was not included on the list of adverse events.

EMA declared that the strong adjuvants used in the vaccines to boost the immune response are safe, yet the five references provided were either non-accessible or irrelevant. We found out that adjuvant safety studies had never been carried out. The manufacturers and regulators say the vaccines are safe because the HPV vaccines and their adjuvants have similar harm profiles.[1360] This is like saying that cigarettes and cigars are safe because they have similar harm profiles. The adjuvants are not safe.[1361]

EMA allowed the companies to lump the "placebo" groups in their trials although, in almost all cases, the "placebo" was an adjuvant or a hepatitis vaccine. EMA's Director Guido Rasi explained to the Ombudsman that "all studies submitted for the marketing authorisation application for Gardasil were placebo controlled," and EMA's official report also gave this false impression.

EMA did its own literature searches but withheld the results from its scientific advisory committee. The withheld reports revealed that HPV vaccines, other vaccines and perhaps also the adjuvant (in combination with an otherwise harmless virus infection) might cause POTS or CRPS. It looked like a cover up that EMA withheld this information, and EMA's attempts at explaining away their actions were highly implausible.[1362]

EMA claimed that none of its experts had financial interests that could affect their impartiality, but the chair of the Scientific Advisory Group, Andrew Pollard, had declared several conflicts of interest in relation to HPV vaccine manufacturers, and other advisors also had such conflicts.

When we found out that Guido Rasi had not declared that he is the inventor of several patents, we were contacted by Carter-Ruck solicitors in London who wrote to us that our comments were "highly defamatory" and that Rasi had never had any economic rights or financial benefits from his patents. They asked us to publish a correction and an apology withdrawing "these false allegations … in terms to be agreed." This was the start of an absurd correspondence that lasted three months where we were asked to state as fact information, we could not verify. We refused to change anything, and Rasi's white colour gorillas ultimately gave up.

Both the Uppsala Monitoring Centre, a WHO collaborating centre, and the Danish health authorities had found signals of harm and were dissatisfied with how their observations and reports were dismissed by EMA. In our view, EMA had committed scientific misconduct.

There is no doubt that serious harms of vaccines occurring in clinical trials are vastly underreported because the investigators know that it is very laborious to report them and invites trouble. When I worked as a doctor and reported to a company conducting a trial of an AIDS drug that a patient had experienced a serious adverse event that I was convinced was drug related, it caused me a lot of work, with endless negotiations with the company and the filling out of many forms. The general sentiment at my department was that we better avoid reporting serious harms, in particular if we considered them drug related, as we did not have the time for all the follow up it caused.

**Requiem for the *BMJ***

In September 2016, Karsten Juhl Jørgensen and I submitted a paper to *BMJ* about EMA's mishandling of its investigation. Unfortunately, *BMJ's* insurance won't cover the costs of a libel lawsuit if the editors don't follow the advice of their lawyers. This is a hindrance for free scientific debate, and we failed to get our paper accepted after a most remarkable process.

After three months, the editors replied that our article was too broad and unfocused and that the "tone" needed a substantial amount of work. When editors speak about the "tone," they are usually worried about possible litigation.

We submitted a second version, but even though there were no peer reviews, it took seven months before *BMJ* replied that "the style and format is not quite right."

We submitted a third version, and it now took six months before *BMJ* replied, again without any prior peer reviews. The editors still wanted changes done.

We submitted a fourth version. Seven months later, *BMJ* rejected our paper. The editors wrote that the peer reviewers' reports were available at the end of their letter but there were none. The Editor-in-Chief, Fiona Godlee, apologised it had taken so long. She was still interested but recommended a "restructuring and toning down." She alerted us to a piece of

information we had overlooked in EMA's 256-page internal, confidential report, suggested an outline for a revision and offered to edit our paper.

We submitted version five. Four months later, we received version six, edited by Navjoyt Ladher, with questions imbedded in the manuscript we responded to. Two months later, we received version seven to which also editor Peter Doshi had contributed, with quite many questions. This was a major setback. I told Ladher that we were now in a catch-22 situation. We wondered why these very high demands, which seemed impossible to meet, were not raised earlier, before the editorial rewriting of our paper. We also noted that the comments by Doshi applied to a much older version, and that we had already taken them into account.

Next, the process became absurd. Ladher had forgotten to send us the comments from *BMJ's* lawyer who had asked if we could document what we had asserted. He also felt there was too much self-citation and asked for alternative citations.

I responded that, as no one else than us had done the huge detective work, we needed to cite ourselves a good deal. We had 20 references, and 7 were to our own work and letters we had written. Three of these were our complaints to EMA and the Ombudsman, and our views on the Ombudsman's decision. Two were our published papers based on the clinical study reports we had obtained from EMA (no one else had ever reviewed this huge material). One was a paper we published with Doshi in *BMJ*: *Challenges of independent assessment of potential harms of HPV vaccines*, also a highly relevant paper. The last one was our criticism of the Cochrane HPV vaccine review, also highly relevant.

Ladher replied that too much of the supporting evidence was not included in the piece itself but relied on readers looking up references and trawling through hundreds of pages. The lawyer suggested that more of what we were saying needed to be in the paper.

Like a bull in an animal show, we were now being drawn around by the nose. I replied that we had been told earlier that our paper should be short and that *BMJ* had deleted a lot when they rewrote it. We affirmed that we were willing to do what *BMJ* required of us but felt the demands were being raised all the time.

Ladher replied that the Ombudsman's findings needed to be included and made much clearer. I replied that we would love to discuss the Ombudsman's findings but that it would make it a rather long article, which we had not been allowed earlier. We had explained elsewhere that the Ombudsman was inconsistent. She said she would not go into scientific issues but nonetheless uncritically accepted EMA's scientific explanations while ignoring us when we explained - multiple times - that they were wrong.

As we were confused by *BMJ's* conflicting messages, I asked Ladher to tell us what they wanted. She replied that their lawyer had advised not to publish any links to my website, as it was not clear if the *BMJ* would be liable for the content of the links, some of which he saw as defamatory. I noted that this seemed to be a catch-22, as some of the most important documents were not publicly available elsewhere, e.g. our complaint to the Ombudsman and EMA's 256-page briefing note to experts.

Ladher replied that we could not refer to leaked confidential material, i.e. EMA's briefing note to experts, as the lawyer was wary about a potential breach of confidence.

I noted that EMA had known for several years that we and others had made the briefing note publicly available and that it was leaked to a journalist already in 2015. I also noted that the *BMJ* had published papers based on leaked confidential reports, e.g. an Eli Lilly report about olanzapine.[1363]

But the absurdities increased. Ladher said that unnamed individuals could complain and consider their work was being impugned and that Andrew Pollard, who was named, might

also complain. I replied that Pollard's conflicts of interest were publicly available; that we only wrote about what we had documented, which is allowed according to British law and would be considered a fair comment; and that unnamed people couldn't possibly sue for libel, as they could not claim they had been harmed.

Ladher asked us to revise our paper yet again, after which it would be sent for legal review again. I asked why the *BMJ* invited resubmission after having set up a catch-22 two and a half years after we submitted a revised version of our paper.

Ladher sent a new version of our paper, with editorial comments inserted that we should respond to. But, for the second time, the *BMJ* sent us the wrong version, with comments we had already responded to. I asked for advice but didn't get any. After another month, I sent a reminder.

Ladher apologised. She had written to their lawyer again for advice about possible ways forward. For example, the editors could say they had seen and verified the source material without needing to include it. I agreed and noted that this method was sometimes used, also in newspapers, and that there were no legal problems with it.

When Ladher wrote back that they were still discussing the issues with their lawyer and that they hoped "these obstacles are surmountable," I lost my patience. I replied that their current lawyer had gone way too far and suggested they got a more reasonable one, in which case they would still comply with their insurance policy. I also noted that one of my friends, Professor Allyson Pollock from Newcastle, had tried for two years to get a paper about the HPV vaccines in the *BMJ*, which they ultimately declined to publish; it was very good and relevant and came out in *Journal of Royal Society of Medicine*.[1364] In 2019, Allyson ensured that Tom Jefferson and I became Visiting Professors at the University of Newcastle.

Finally, I asked for a deadline, which I had done several times before, and I sent a reminder after seven weeks of silence. One month later, I was so frustrated that I copied Godlee on my mail, explaining that I had not heard anything for three months.

During these three years of increasing frustrations with the *BMJ*, I had involved Carl Heneghan, editor of *BMJ Evidence-Based Medicine*. He had suggested that we pulled the paper and submitted it to him, but also that we tried first to keep going with *BMJ's* demands.

We sent our paper to Carl including Fiona's reply, which was a gigantic roadblock. They were "not near being able to make a decision," as our paper "still doesn't make the case securely enough for us to publish in its current form, especially given the controversial nature of what is being said. There are still multiple steps that would need to take place … The major ones are sorting the legal issues, further peer review … and then further revision."

To me, this was the requiem for the *BMJ*. It was no longer a journal where you can speak truth to power. *BMJ* killed our paper but did not have the guts to tell me. This made me very sad because *BMJ* was one of the very few major journals you could go to with inconvenient truths.

I have known Fiona and her predecessor, Richard Smith, for over 30 years; I have published articles with them;[1365] I was on *BMJ's* Editorial Board from the start when they created one, from 1995 to 2002; and I have published far more papers in *BMJ* than in any other journal, 74 in total. What made the *BMJ* behave so badly? If we had made a small error somewhere, so what? This happens in science and then you publish an erratum.

Since *BMJ* journals are obliged to follow the advice of their lawyers, I don't understand how Carl got around this hurdle, but he did. It was easy for us to respond to the three peer reviews he sent, as we had already left no stone unturned. Our paper was published online

in January 2021.[1366] This was 4.5 years after we submitted it to *BMJ*! What a tragedy this was for the *BMJ* and for freedom of speech in science.

In 2019, I submitted a letter in reply to a *BMJ* article about a pending court case where Merck and PTC Therapeutics tried to prevent EMA from releasing clinical study reports (see page 116). This started a bizarre journey. *BMJ's* lawyer wanted to see "clear, persuasive supporting evidence" for my statement that Merck had committed serious misconduct previously.

It had been documented many times, and I highlighted important bits in my 2013 book about these issues, that Merck hid that rofecoxib (Vioxx) caused heart attacks, and that scientists at Merck knew all the time, even before any clinical trials were carried out, that the biochemical properties of rofecoxib meant it must be thrombogenic.

However, *BMJ* became hair-splitting and asked me to pinpoint actual references which said "hid" and "caused." This reminded me of Drummond Rennie who was dragged into court by Pfizer after a lecture where he said that Pfizer laughed all the way to the bank. Pfizer's lawyer asked Drummond: "Which bank?"

I had already given relevant references but supplied additional, highly convincing ones.[1367]

But *BMJ* escalated its absurdities. They wanted me to tell them yet again why scientists at Merck knew that rofecoxib was thrombogenic and asked for specific references about the ulcer effects. I replied, again with references, that "anyone with a chemical background like I have, knew all the time that a drug with this mechanism of action that reduces metabolites of prostacyclin must be thrombogenic. This is very basic biochemical knowledge ... It has been known for decades that all NSAIDs cause ulcers, so I do not understand why you ask me to document this. You can read it in any textbook."

I explained how I had estimated the number of deaths caused by rofecoxib, but *BMJ* wanted to see even more references. I was upset but remained calm and replied that David Graham from the FDA had estimated that rofecoxib had killed 60,000 people.

To avoid any further obstacles, I attached a version that I was certain would satisfy *BMJ's* lawyers. But *BMJ* killed my little letter to the editor. I asked for information twice but did not hear a word from them. I gave up and published an article about this on my website.[1368]

It is very depressing that we can no longer tell the truth about drug harms in medical journals, not even when everything we say has been documented before. Even just to publish a little *Personal opinion* in the *BMJ* proved to be too painful.[1369] In August 2021, I submitted the article, *"Efficacy and safety" and "benefits and risks" of drugs are misnomers.*

Seven months later, I checked *BMJ's* manuscript submission website, as I had not heard anything. According to it, editor Juliet Dobson had replied to me five months after my submission, but I could not find her email anywhere. I wrote to her that, earlier, another *BMJ* editor had made an error and never sent an email registered as sent.

Dobson suggested some revisions, and I sent a new version the next day.

Six weeks later, I asked if she had looked at my resubmission. Nine days later, I asked again and noted that, "In the research networks to which I belong we have had many discussions about *BMJ's* slowness, which is something new. It is also new that *BMJ* sometimes rejects papers after having worked actively with them for 2-3 years, which was something the *NEJM [New England Journal of Medicine]* was known for. In the past, *BMJ* was

much, much faster. I tell you this because we are many who treasure *BMJ*. We do not want it to become a sort of *NEJM*."

Dobson promised to send an edited version "by next week," which became a month, and I asked if she had tried to reach me. A week later, she sent an edited version, and I sent a third version of the paper the next day.

Seven weeks later, I asked if she had seen the new version and noted that "The changes I did to your edits and proposals were very minor."

Three weeks later, I sent a reminder. Dobson replied that she thought some of my mails had gone to her spam folder, and that they had had this trouble before. She promised to check this and get back to me in the "start of the week."

The start of the week became yet another month. I wrote that there seemed to be nothing more to be done with my personal opinion, "So why not accept my paper and publish it?"

Dobson never told me if she had checked her spam folder. I thought that - after having been patient for 15 months - I was close to the finishing line, but Dobson kicked me back to start: "I think some emails have gone astray (other colleagues have had similar experiences) ... I think it does need some more detailed exploration or explanation to the reader as to why you are raising this now, and what this piece adds."

Two days later, I submitted the fourth version.

Three weeks later, I had lost my patience: "Don't you think it is about time that it gets published? … not only I but some of my very sharp colleagues whom you would not like to lose have experienced that it has become virtually impossible to publish anything in *BMJ*. Some have even said: I regard the journal as dead now. You should take this seriously."

After another week, where I had not heard from Dobson, I asked Kamran Abbasi, the Editor-in-Chief, copying Dobson, what was going on, or rather, not going on, at the *BMJ*.

Abbasi replied that I had not explored the issues fully enough.

I sent a fifth version of my paper where I had included the Vioxx scandal to exemplify what I meant. Dobson replied that some additional details were needed and sent an edited version with queries in the margins.

I sent a sixth version. Three weeks later, Dobson replied that she would be in touch "at the start of next week." Two and a half weeks later, she apologised for the delay and spoke again about "the start of next week." Two weeks later, I noted that "It is now another two months."

Dobson replied that it all looked good but that she had one final query regarding Vioxx.

I sent a seventh version the next day: "The only change I made is that I inserted some verbatim text in reply to your question about Vioxx."

Dobson wrote, "I will send you the final proofs on Monday." Ten days later, I wrote: "Monday was last Monday, not today. Just writing to enquire if anything went wrong, as I have missed important emails before." Dobson then sent the proofs, I returned them, and – lo and behold - my paper was published.[1370]

Dobson's interventions improved my paper, but the harms exceeded the benefits. The process took one and a half years, and the delays on my part constituted only two weeks of this. If I had known this in advance, and also that I needed to accept editorial changes I disagreed with, I would never have embarked on this Odyssey.

Dobson downplayed drug harms, just as the drug industry does. This is particularly inappropriate for an article called *Personal opinion*.

I wrote in my manuscript: “No drug is safe,” which Dobson changed into: “No drug is completely safe or without side effects.”

I wrote: “Drugs always harm some people, otherwise they wouldn’t work,” which Dobson changed into a pleonasm: “Drugs always have an effect, otherwise they wouldn’t work,” adding: “so there is always a risk of harm to some people, even if minimal.”

She allowed me to write that “All drugs have harms,” but added: “even if small or infrequent.”

Dobson’s editorial changes were seriously misleading, as they disregard the evidence. A random check of package inserts will reveal that most drugs have frequent and serious harms. The harms of drugs are not “small or infrequent;” the “risk” of harm is not just a risk, it is very real; and it is not “minimal.”

**Misleading the public, editorial misconduct, harassments and a lawsuit**

The Danish Board of Health launched a public campaign in 2017 emphasising that systematic reviews of randomised trials are the most reliable evidence we have, but they ignored that, in the almost total absence of placebo-controlled HPV vaccine trials, such reviews are less reliable than other types of research for studying vaccine harms. They quoted EMA’s flawed consensus report when saying that the vaccines are safe, even though consensus reports are at the bottom of the evidence hierarchy.

The Board cherry-picked the references they quoted and reacted with considerable arrogance when criticised.[1371] On their website, they provided references in support of their position, but important studies carried out by the Uppsala Monitoring Centre were missing. The Centre found that POTS was reported 82 times more often for the HPV vaccines than for other vaccines.[1372] They also noted that a combination of headache and dizziness, with either fatigue or syncope, was more often reported in HPV vaccine reports than in non-HPV vaccine reports for young women, and that this disproportionality remained when countries reporting the signals of CRPS (Japan) and POTS (Denmark) were excluded.[1373] The Uppsala researchers avoided any possible media attention influence on reporting by including only cases reported before 2015. Even so, they identified a greater number of potentially undiagnosed cases than the total number of cases reported by the drug companies when EMA asked them to find cases in their databases.

Contrary to EMA’s statement to us,[1374] it is not “a very conservative approach” to let drug companies exclude many cases diagnosed by a skilled Danish clinician without inspecting the underlying raw data, or to trust drug companies when they report far fewer cases than the Uppsala Monitoring Centre found.

At a Danish Medical Association meeting on 15 August 2017, I addressed EMA’s poor work and noted the lack of placebo-controlled trials. The director of the Board of Health, Søren Brostrøm, became very aggressive and alleged that there was a trial where 4,000 had received placebo and that I had climbed high up in a tree and could be mistaken. I replied that I didn’t climb trees but had both feet on the ground, and that not a single trial was genuinely placebo-controlled.

Brostrøm called it alternative facts when researchers were sceptical of the work done by the drug companies and EMA and said that opposition to the vaccines shows that we live in “a postfactual society.” Such remarks do not bolster confidence in the authorities. He also called the declining HPV vaccination rate “a catastrophe lurking just around the corner.”

I could not see any catastrophe. First, only about 100 women in Denmark die from cervical cancer annually, whereas 60 times as many women die from smoking. If we want to help women survive, we should convince young girls not to start smoking.

Second, we don't know for sure if the vaccines lower mortality from cervical cancer, or by how much if they do.[1375] They lower the risk of infection with some HPV strains that can cause cancer and of cell changes that are precursors to cancer. But they are only about 70% protective against these HPV strains and other strains can cause cancer. Moreover, most cell changes will disappear if left untreated.[1376]

Third, when will the possible benefit come? About half of those who die from cervical cancer are over 70 years of age. And a systematic review of the published trials from 2017 found more deaths in the vaccine groups than in the control groups (14 vs. 3, P = 0.01),[1377] which occurred at a much younger age. In Spain, a young woman with mild asthma had a severe exacerbation after the first dose, and after the second, she was admitted to an intensive care unit where she died.[1378] A girl drowned in a bath-tub in Sweden, after a post-vaccination clinical course dominated by syncope spells. There are many other deaths after HPV vaccination in the Uppsala database even though most doctors do not report their suspicions of serious harms because they have been reassured that the vaccines are safe.

Fourth, instead of getting vaccinated, a girl can attend screening, which is recommended even for those vaccinated. Cervical cancer grows so slowly that screening can prevent virtually all cancer deaths. Screening is not ideal, as it increases conizations (removal of part of the cervix), which double the risk of preterm birth,[1379] but is a viable alternative.

Half a year after my debate with Brostrøm, I became the subject of an evil attempt at character assassination in a large article, *The hair in the medical soup*, in the newspaper *Weekendavisen*.[1380] This was the worst and most mendacious journalism I have ever been exposed to in a major newspaper. Brostrøm said in the article that I was looking for a tiny hair in the medical soup instead of looking at the soup. He referred to our ongoing research on the harms of the HPV vaccines and criticised that I had used my energy on complaining about EMA. At a meeting I had with him and the Minister of Health in August 2018, I asked if he would still call it a hair in the soup if we found that the vaccines caused serious neurological harms (which we did[1381]). He did not reply.

Journalist Poul Pilgaard Johnsen had the hidden agenda that I should be destroyed, and he broke his promises to such an extent that I complained to the Press Council, noting that "If scientific arguments show we have been wrong in our research or announcements to the public, we are willing to admit it. But there are no concrete examples in Johnsen's article on alleged errors we can relate to." The Press Council reprimanded Johnsen for insufficient submission of a source's critical statement and for not including my comments on another source's critical statement in the article.[1382] But the damage was done and cannot be undone.

The first word in the article was "Darkened," and I was described as a cantankerous person with such words that it suggested I had a psychosis. The source was anonymous, but it was likely Poul Videbech who said in Johnsen's article that I had an enormous influence in the media and on public opinion. Psychologist Allan Holmgren cited this in a critical letter he published in *Weekendavisen*.[1383] He noted that the purpose of the article was to commit character assassination, and that it was a question of power. As I had too much power, I must be destroyed.

Johnsen's article only conveyed views from people who did not agree with my science. It was full of unsubstantiated claims, attitudes and erroneous statements from people representing power bases or interests that we had challenged in our research.

The article caused Liselott Blixt, chair on the Committee on Health in Parliament, to ask if the minister was concerned that several professionals, including the director of the Danish Board of Health, the chair of the Danish Medical Societies and the head of the Oncology Clinic at Rigshospitalet, in *Weekendavisen* in rather strong terms had criticised me in relation to the discussions about the HPV vaccines and happy pills.[1384] She also asked if the minister intended to do something. The minister replied that it did affect her and that she would consider the criticism that was raised.[1385] I had a very good relation to Blixt who appreciated what I did. She later told me it was not her idea to ask the minister. Others had asked her, as chair for the committee, to do so.

Our complaint over EMA started a bizarre witch-hunt by people in senior positions who embarrassed themselves and their institutions by spreading false information.

In March 2017, Michael Head et al. published an e-letter in a pretty unknown journal, *NPJ Vaccines*, where they called my research group anti-vaxxers already in the title.[1386] The web address includes www.nature.com, which made some people believe the letter was published in *Nature*. Head complained that we used the Nordic Cochrane Centre's letterhead when we wrote to EMA and the European Ombudsman. They had raised the matter with the Cochrane Steering Group but did not tell their readers that Cochrane had replied that we had used correct affiliations and had not stated that our complaint over EMA was prepared on behalf of Cochrane.

Head et al. claimed that the impression that we had obtained a Cochrane stamp of approval was being promoted in online anti-vaccine communities. This was also false. They gave two references, but its authors clearly noted that the letter to EMA came from the Nordic Cochrane Centre.

It was a non-case, and nothing should have come out of it. But Springer, that owns *NPJ Vaccines*, exposed us to horrific censorship. They tried to avoid publishing our rebuttal. The editors also misbehaved. After exchanges of many emails discussing nitty-gritty things in our reply, it had still not been published more than two and a half years later, even though we had accommodated all the editors' comments. Our reply[1387] came out 3 years after Head et al.'s letter - and only because we had threatened Springer with litigation (see below).

Influential people in Denmark abused Head et al.'s letter in a most spectacular fashion. The director of the Danish Drug Agency, Thomas Senderovitz, tweeted: "@PGtzsche1's erroneous criticism of EMA's assessment of #HPV vaccine side effects on @CochraneNordic paper is problematic" and "Precisely! Excellent post pointing out misinformation from Nordic Cochrane" in response to a tweet by Karen Price: "How easy is misinformation???" This was "liked" by the chair of the Danish Medical Association, Andreas Rudkjøbing.

Leif Vestergaard tweeted: "unacceptable confusion. And they always criticise others for conflicts of interest!"

The Danish Cancer Society's former chairman, Frede Olesen, tweeted: "A must read in *Nature* about HPV. Should be quoted in all Danish periodicals and newspapers and read by HPV sceptics or those who still have confidence in the Nordic Cochrane Centre." He also wrote on Facebook: "Article in '*Nature*,' the world's best scientific journal - clearly refutes the fear of the HPV vaccine and clearly denounces the dissemination of false science through the Nordic Cochrane Centre."

This was pure fabrication. The article was not about our dissemination of science, the journal is not *Nature*, and we have never disseminated false science.

Journalist Ole Toft tweeted: "The Nordic Cochrane Centre (again) received harsh criticism - now in the HPV case in *Nature*. Both scientifically and by abusing Cochrane's credibility." Also pure fabrication, and there was no criticism of our scientific work in the e-letter.

Videbech wrote on Facebook: "The Nordic Cochrane Centre gets criticism again – supported by the international Cochrane Collaboration Steering Group. This time in *Nature* itself … It is extremely worrying - is the Nordic Cochrane Centre closing itself down? What a tragedy for the Cochrane work!"

Once again, pure fabrication. We were not criticised by the Cochrane Steering Group.

Stinus Lindgren from a Danish political party upped the lies. On Facebook, he wrote that I had made comments against the HPV vaccine; that I had abused "Cochrane's good name and reputation"; and that "two of the leaders in Cochrane had asked the authors to publicly disclose this information to emphasise that this is not Cochrane's official view." There was absolutely nothing about any of this in the letter from the Cochrane Steering Group.

Line Emilie Fedders, the Danish Agency for Patient Safety noted: "Is the Nordic Cochrane Centre still on government finances with the aim of conducting impartial research?"

It is disastrous when people in key positions circulate derogatory, defamatory and false comments about an issue they didn't even investigate before they pressed the send button. I don't think any of them had read the e-letter, as it was clearly not published in *Nature*. This "shoot before you ask" mentality not only undermines their authority, but also displays their hypocrisy. The authorities and similar institutions had complained wide and loud about fake news being spread on social media about dangers of vaccines while they happily contributed to spreading fake news themselves about a research group whose only interest was to get as close to the truth as possible.

An obvious aim of all these groundless personal attacks was to keep me busy defending myself, giving me less time to spend on my research and communication of the evidence to the public. It was a David versus Goliath situation. Those who defended the status quo did not need to back up their opinions with evidence; the journalists let them get away with the most horrendous statements.

In my vaccine book, I described a case of editorial misconduct related to an animal study.[1388] I met with the lead author, Lluís Luján, at a meeting in Copenhagen in 2022 where he talked about his study in relation to the screening of an excellent documentary film, *Under the skin*, by Bert Ehgartner.[1389] This film describes the harms of vaccines that contain aluminium adjuvants, and its main focus is the HPV vaccines.

Lluís demonstrated neurological harms of an aluminium adjuvant used in a vaccine for animals. Compared to placebo, sheep injected with the adjuvant or the vaccine had fewer affiliative interactions and more aggressive interactions, stereotypies, excitatory behaviour, and compulsive eating.

The study was published online in *Pharmacological Research* but was retracted by the editor, Professor Emilio Clementi, and cannot be read any longer,[1390] in violation of Elsevier's guidelines. A "concerned reader," likely David Hawkes, a troll financed by a vaccine manufacturer, had submitted comments with almost no scientific foundation, which were written to deceive and to give the appearance of "scientific credibility." There were many elementary errors in his comments. Lluís replied that he did not understand why the commentator was anonymous. He offered to make the raw data available for independent sta-

tistical analysis and used seven pages to rebut the "concerns." His discussion of the issues is convincing, and the journal's statistical editor advised against withdrawal of the paper. But Clementi wouldn't listen.

The story about the Cochrane review of the HPV vaccine trials is embarrassing for Cochrane (see page 364). The systematic review that my research group did,[1391] is much more reliable than the Cochrane review because we used the clinical study reports submitted to EMA. It was accepted for publication in *Systematic Reviews*, owned by Springer, on March 6, 2019. However, a year later, it had still not been published, although the journal promises publication within 20 days of acceptance.

Our email correspondence with the journal takes up 66 pages, and we received 20 apologies and a variety of odd, contradictory, and implausible reasons for why our paper had not been published.[1392] On February 16, 2020, we wrote to Springer that it seemed they deliberately delayed publication and highlighted that their scientific censorship borders on scientific misconduct and fraud. We warned that if Springer failed to publish our papers – including our letter to *Npj Vaccines* - before 1 March 2020, we would involve our lawyers.

This caused Springer to publish our review and letter with record speed, in just 12 days, two days before our deadline.

During the stalling of our papers, we sought an explanation from the journal's Editor-in-Chief, David Moher, who put the blame on Springer: "The delay is a substantial embarrassment … We have experienced some internal issues at *Springer Nature*."[1393] When Maryanne Demasi asked whether it had any financial conflicts of interest, *Springer Nature* strenuously denied any external influence on its decision-making process, stating: "With a company the size of *Springer Nature* it is difficult to know for certain whether any of our advertisers, authors and subscribers are associated with the pharmaceutical industry, or manufacturers of the HPV vaccine or other HPV therapies."

So, if a medical student is asked if he ever cheated in an exam, he could say: "With a university this size it is difficult to know for certain whether any of our administrators, researchers, teachers and students have cheated."

All three Editors-in-Chief of *Systematic Reviews* announced they were stepping down, but none responded to Maryanne's numerous requests for comment about their reasons.

Getting access to the HPV vaccine study reports had been very frustrating.[1394] Since 2010, EMA's policy had been that access to documents required that there was an overriding public interest in disclosure that "can be identified by the Agency." This violated the Ombudsman's decision in 2010 (see page 112). EMA denied our request because it "would undermine the protection of commercial interests," which was also incorrect. We appealed, and EMA approved our request.

We had identified 48 studies, but EMA only held 29 clinical study reports, which they released in 61 batches. The reports lacked important sections, such as protocols, serious harms narratives and appendices, and most reports had redactions of allocation numbers, vaccine batch numbers, study centres and participant ID numbers, which hindered our work. The many batches made it difficult to keep track of the data, e.g. one study report (HPV-008) of 4,263 pages was released in 17 files across 7 batches over 12 months.

EMA released the study reports with extraordinary slowness. After three years, we went ahead with what we had, which was the major trials.[1395] We had considered obtaining the reports from the vaccine manufacturers, but Merck required that researchers don't disclose

data to third parties, and GlaxoSmithKline granted access to trial data through a portal that prohibited the download and public distribution of data. These policies conflicted with our aim of making the underlying data publicly available. Moreover, the reports GlaxoSmithKline publishes are useless, as they are heavily redacted.

We included 24 clinical study reports that comprised 79% of the total eligible sample of trial participants.[1396] Against all odds, as the control groups had active comparators, we found that the HPV vaccines increased serious nervous system disorders significantly: 72 vs. 46 patients, risk ratio 1.49 (P = 0.04).[1397] We called it an exploratory analysis, but it was the most important analysis because the suspected harms to the autonomic nervous system were what caused EMA to assess vaccine safety in 2015.

POTS and CRPS are rare syndromes that are difficult to identify, and we knew that the companies had deliberately concealed the harms. Not a single case of POTS or CRPS was mentioned in the study reports. To assess if there were signs and symptoms consistent with POTS or CRPS in the data, we did another exploratory analysis where we asked a blinded physician, Louise Brinth, to assess the coded terms. The HPV vaccines significantly increased serious harms definitely associated with POTS (P = 0.006) or CRPS (P = 0.01). New onset diseases definitely associated with POTS were also increased (P = 0.03).

To put it mildly, our review was not welcome in Cochrane. When our PhD student, Lars Jørgensen, submitted it to the annual Cochrane Colloquium in 2018, it was rejected, whereas another submission by him, *Addressing reporting bias in systematic reviews*, which was far less important, was accepted.

Lars communicated our results for the first time at the Nordic Cochrane Centre's 25th Anniversary Research Symposium on 12 October 2018. The media were present but did not pay attention to our findings. When Lars defended his PhD thesis half a year later, the media announced there was nothing to worry about and that I had chosen three examiners who were all biased against the HPV vaccines! The headline in *Berlingske* was: *The University of Copenhagen approves controversial HPV research: "Is it about promoting some anti-vaccine agenda?"*[1398] It was like a religious fight. The three examiners were described as vaccine heretics, which they weren't. They were highly qualified. One, Rebecca Chandler from the Uppsala Monitoring Centre, knows a lot about the HPV vaccines and was EMA's rapporteur for one of them. Another was Kim Varming, an immunologist with an interest in the vaccines and an expert on harms caused by autoimmune reactions. The third, John Brodersen, has a long-standing interest in cancer screening and he led the defense.

The university rejected the journalists' primitivism, stating that they sustain academic freedom in research.

Currently, the attorneys at the Wisner Baum law firm in Los Angeles are in active litigation against Merck in state and federal courts.[1399] I interviewed Michael Baum in November 2023 about these activities for our *Broken Medical Science* channel, and he said they had close to 30 million pages of internal Merck documents.

The lawsuits allege Merck conducted fraudulent clinical trials with their Gardasil vaccine and failed to warn about severe side effects, which can remain serious for years after the jab. Michael hired me as an expert witness and I read 112,000 pages of clinical study reports, which I wrote a report about.

I went to Los Angeles for my deposition in November 2024 where Merck's lawyer grilled me for a whole day. It was an awful experience I have written about in another book.[1400] I was scheduled to appear in Los Angeles Superior Court in January 2025 but when the trial

started, the judge announced that she would not allow a full month for the proceedings, so Michael needed to cancel the oral testimony of three of his expert witnesses, including me.

Whatever happens, it is pretty certain that the verdict will be appealed, either by Merck or Wisner Baum that have prepared for the court case for eight years, with the involvement of other law firms.

In December 2014, Tony Lyons, the CEO of Skyhorse, which published my vaccine book, wrote to me because Bob Kennedy had told him I worked on a book about the HPV vaccines. I sent him my draft and they offered publication "through our imprint with Children's Health Defense." I replied I had supported Bob a lot on X and was thrilled that he was now secretary of state because we agreed on most issues, apart from vaccines, with two important exceptions, which I mention in an interview on our film channel.[1401] I noted it would be counter-productive if I published a book with the imprint of Children's Health Defense. It is regarded as the main anti-vaxxer institution in the USA, and the leading figures believe steadfast in the debunked idea that the MMR vaccine causes autism. I asked to have my book published without any reference to this organisation, which was accepted.

## Measles

A small minority, around 1-2% in high-income countries,[1402] are opposed to all vaccines. These people are very harmful, as they are highly vocal and influential. A US survey showed that 10% of adults believe that vaccines can cause autism and 46% are unsure.[1403] This belief is based on totally fraudulent research by Andrew Wakefield, which I describe in detail in my vaccine book.[1404] He published it in *The Lancet*, and its editor, Richard Horton, protected him in a disgraceful way, claiming he had been cleared of wrong-doing, which was false. It took *Lancet* 12 years to retract Wakefield's paper after intense outside pressure and even then, they only mentioned minor issues although the paper is fraudulent on many counts.[1405]

Perversely, the retraction of Wakefield's fraudulent paper is often cited by anti-vaxxers as evidence of a "conspiracy" to suppress his views.

I explain in my vaccine book why the film, *Vaxxed: from cover-up to catastrophe*, is a catastrophically bad film. It was directed by Wakefield and produced by medical journalist Del Bigtree who praised him and compared him with Galileo. The film is highly manipulative. It propagates bogus conspiracy theories and makes much of a claim that researchers from the US Centers for Disease Control and Prevention (CDC) had committed fraud when they investigated a possible link between autism and the MMR (measles, mumps, and rubella) vaccine. There is not a shred of reliable evidence that this was the case, and the film does not mention that a study by Brian Hooker, who claimed this, has been retracted.

The harm Wakefield has caused is colossal. The measles vaccine is one of the best we have. According to the WHO, measles vaccination averted 57 million deaths between 2000 and 2022, but in 2022, there were an estimated 136,000 measles deaths globally, mostly among unvaccinated or undervaccinated children under the age of 5.[1406] Before the vaccine was introduced in 1963, major epidemics occurred causing an estimated 2.6 million deaths each year.

The anti-vaxxers are killing children. An unvaccinated child in Texas died of measles in February 2025, and at least 124 people were infected in West Texas, all but five unvaccinated and most of them children.[1407]

I am against mandatory vaccination and have explained why in my book. But the threat to children, who cannot make decisions about vaccines for themselves, could become so large that I might favour mandatory vaccinations of children in special circumstances.

In 2019, I had accepted to talk about this at a meeting in California. I was immediately attacked by physician David Gorski: "Holy crap @PGtzsche1, formerly of @CochraneNordic, has gone full on antivax. Here he is scheduled to speak at a workshop for the antivax doctors group with the Orwellian name Physicians for Informed Consent."

As I had never given such a talk before, Gorski had no idea what I would talk about, or what my motives and background were. He nonetheless said that "The bottom line is that @PGtzsche1 had become an antivaccine crank and deserves to be dismissed as such."

Anti-vaxxer is a derogatory term some people throw at anyone they don't like. The US Merriam-Webster dictionary defines an anti-vaxxer as "a person who opposes vaccination or laws that mandate vaccination." Thus, UNESCO seems to be an anti-vaxxer agency because it opposes treatment without informed consent. UNESCO's Universal Declaration on Bioethics and Human Rights says that "Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information."

Perhaps we should just ignore idiots like Gorski who behaves like a terrorist on social media and might be a troll because he is very prolific. He is one of the founders of the blog, Science-Based Medicine, that despite its name is a forum for his evil smear campaigns against anyone who does not agree with him.

After I had asked the chair who the other speakers were, I cancelled my participation, paid back the advance, and covered the costs myself that I could not get refunded. One of the speakers, Mary Holland, exonerated Wakefield. She is CEO at Children's Health Defense. Another one, Tony Bark, preferred homoeopathy for vaccines although she was a doctor.

Later, I discovered that the founder of Physicians for Informed Consent, Shira Miller, had written seriously misleading information about the MMR vaccine. She claimed it has not been proven that it results in fewer deaths or permanent disability than what is expected from measles.[1408] Her estimates are invalid; she compares apples and oranges; and the worst blunder is that the reason that so few people die is that almost the whole population is vaccinated. We have not only eliminated smallpox, diphtheria, polio, and measles, we have also eliminated the memory of these terrible diseases.

In 2016, I discovered that my portrait was on the front page of the website of the US Alliance for Human Research Protection under *Honors Exemplary Professionals*. Portraits came and went in slow succession, and I couldn't believe it when Wakefield appeared, at the end of the gallery. I contacted the founder of the alliance, Vera Sharav, but she defended Wakefield vigorously with false arguments and preferred to let me go rather than removing him. I felt abused because my credibility had been used to shine a good light on Wakefield without my knowledge.

In 2021, Sharav propagated conspiracy theories about the COVID-19 pandemic and made unjustified comparisons with Nazi Germany.[1409] She claimed that the pandemic had exposed eugenics driven public health policies in Europe and USA, which was a chilling replay of T4 (a campaign of mass murder by "euthanasia" in Nazi Germany). And government directives to hospitals and nursing homes essentially condemned the elderly to death, Sharav said. The interviewer, German lawyer Reiner Fuellmich, did not ask a single critical question.

## Influenza

The influenza vaccines are not very effective, and the trials have not shown that they reduce absenteeism, hospital admissions, bacterial pneumonias or deaths.

Many people and institutions who want us to believe the vaccines save lives are scientifically dishonest. After a Cochrane review of elderly people had not found any effect on mortality, a group of researchers "rearranged" the data and reported that the vaccine reduced deaths[1410] - an amazing statistical stunt considering that the risk ratio was 1.02 and only four people died. The researchers did this "after invitation from Cochrane."[1411]

The authorities also lie. The FDA wrote that "A lot of the illness and death caused by the influenza virus can be prevented by a yearly influenza vaccine."[1412]

Oddly, a 2021 trial found that vaccination decreases mortality if given shortly after myocardial infarction.[1413] I don't know what to make out of this, as the result is in total contrast to those from other trials. The trial was stopped early, and it is not plausible to me that the flu shot would work for these patients and not for others.

It was very difficult to find anything about the harms. The FDA page about safety just advised service people to get vaccinated. The CDC claimed, based on their review, that influenza vaccination of health care personnel can enhance patient safety, but there is no reliable research in support of this, and some of the results were absurdly misleading. One study claimed a 29% reduction in deaths, which is not possible, as influenza has been estimated to contribute to less than 10% of all winter deaths among elderly people. As the commonly used vaccine is not a live vaccine, it could even increase mortality. Moreover, the CDC did not mention the relevant Cochrane review, which found no reliable support for vaccinating healthcare workers who care for the elderly in long-term care institutions.[1414] As this review was first published in 2006 and updated in 2010, 2013, and 2016, and as the CDC searched in the *Cochrane Library*, the CDC must have avoided to mention the review deliberately. This is fraud.

The CDC recommended that all US healthcare workers get vaccinated annually against influenza. Its website is a treasure trove of misinformation, even worse than drug company websites. It announces colossal effects of vaccination without the slightest hint that these estimates come from highly unreliable research such as case-control studies.

About harms, the CDC website mentioned mild soreness at the injection site for a day or two. But there are many more harms, also serious ones, e.g. anaphylaxis, which can be deadly.

When doctors first alerted their colleagues to the possibility that Pandemrix, used during the 2009-2010 pandemic, had caused narcolepsy in young people in Sweden and Finland, they were ridiculed. Narcolepsy is a life-long, seriously debilitating condition with poor treatment options where people suddenly fall asleep, with an onset from about two months after vaccination and up to at least two years later. The likely mechanism is an autoimmune cross-reaction between the active component of the vaccine and receptors on brain cells controlling the day rhythm.[1415] More than 1,300 people developed narcolepsy from Pandemrix and GlaxoSmithKline settled claims out of court.

Four Canadian studies have shown that people who receive a seasonal influenza vaccine have an increased risk of getting infected with another strain the next year.[1416] The CDC also admits that repeated vaccination can weaken the immune response.[1417]

Since there is a price to pay for stimulating the immune system, it seems irresponsible to advise people to get a flu shot every year for their entire life. This is a gigantic, uncontrolled experiment with human beings.

Drug treatment is also an area plagued with fraud. Roche claimed, based on unpublished research it refused to share with others, that oseltamivir (Tamiflu) reduces hospital admissions and complications to influenza. I suggested that governments should sue Roche and boycott its products because of this consumer fraud.[1418] An insider told me that governments don't sue because they don't want to lose face. A face lifting at a price of billions.

In 2015, *The Lancet* published a meta-analysis of the effects of Tamiflu[1419] funded by Roche through two thinly disguised intermediary bodies and using data supplied by Roche. The intent was to discredit a much better meta-analysis published by Tom Jefferson and colleagues a year earlier in *Lancet's* competitor journal, the *BMJ*.[1420] In contrast to the *BMJ* paper, *Lancet* reported that Tamiflu reduced lower respiratory tract complications and hospital admissions. Tom told Richard Horton, *Lancet's* editor, that one of the authors had made *a million dollars* out of being on the board of Gilead Science, the patent holder of Tamiflu. Horton didn't reply.

Influenza drugs are useless. FDA's advisory committee rejected zanamivir (Relenza) with the votes 13 to 4 because it was no better than placebo when patients were taking other drugs such as paracetamol.[1421] But the FDA approved it.

The CDC director told the public that these drugs could "save your life," which looked like classic stealth marketing where the industry places fraudulent messages in the mouths of trusted third parties. In 2018, the CDC claimed that "Antiviral drugs are an important second line of defense to treat the flu."[1422] This was several years after we knew for sure that they weren't. The CDC has degenerated into an agency propagating industry friendly nonsense. We cannot trust anything this agency says about the necessity of being vaccinated or of using antiviral drugs.

On her last day of work, in July 2020, University of California President Janet Napolitano issued an executive order mandating flu shots for everyone as a condition of continued employment and continued school enrolment for students. The justification was to mitigate a possible future shortage of hospital beds, if there was a second wave of COVID-19 and if there was a big seasonal flu outbreak.

This was a serious human rights violation. Only one-third of US adults got an influenza vaccination. In a declaration in support of plaintiffs' motion for a preliminary injunction to the superior court, I explained that Napolitano quoted the literature so selectively that it was scientific misconduct according to the definition by the US Office of Research Integrity.

Unfortunately, judges focus on authority rather than evidence. Our motion was denied even though the other side only provided opinions and personal experiences while we provided solid scientific arguments. The judge was even made credibility determinations. The other side had specialists in infectious diseases whose views were in line with the CDC's strong and misguided recommendations that everyone should get a flu shot. The judge also let his private views play a role saying he would be afraid of sitting next to someone who wasn't vaccinated, and he made a ridiculous analogy to drunk driving.

I expected that flu shots would increase the risk of serious COVID-19, which was confirmed in a large observational study that found that COVID-19 deaths were associated with the influenza vaccination rate ($P < 0.001$).[1423] The degree of lockdown and the degree of requirement for mask use in public were not associated with mortality rates.

## The DTP vaccine and the deplorable role of WHO and Cochrane

It looks like a no-brainer that we should all get the trivalent diphtheria, tetanus, and pertussis (DTP) vaccine because these three diseases are horrible and kill people. But it is not that simple, which I wrote a report about.[1424]

Peter Aaby found that the DTP vaccine increased overall mortality in Guinea-Bissau and other low-income countries. This didn't make him popular at the WHO headquarters, and the WHO published a report in 2014 in response to his findings.

I updated WHO's literature searches and found two additional, highly relevant studies where Aaby had improved on his methods in response to criticisms raised in the WHO report. The two studies found that the DTP vaccine doubled mortality. Moreover, all studies that had analysed existing data sets collected for other purposes suffered from substantial biases that led to underestimation of the mortality risk of the vaccine.

There were major problems with the WHO report. Although it noted that most studies showed a deleterious effect of DTP, the authors concluded that the results were inconsistent because two studies showed a beneficial effect. However, some heterogeneity will always occur in observational studies, and these two studies did not find a significantly beneficial effect on mortality. Furthermore, they were so biased that they should have been excluded.

The authors did not provide summary estimates because WHO's working group had requested that meta-analyses not be done. This is an unacceptable interference with research by a group that includes people with numerous financial conflicts of interest in relation to vaccines, and the reasons offered for not performing meta-analyses were invalid. It is difficult to understand why this demand - which I have never seen elsewhere - was introduced unless the WHO did not want to run a risk of receiving a systematic review that concluded that the DTP vaccine increases mortality.

WHO's experts, who advised against using meta-analysis, wrote, after having seen the WHO report, that the data suggested that both the BCG vaccine (Bacillus Calmette-Guérin vaccine, against tuberculosis) and the measles vaccine reduce all-cause mortality. I checked this claim by doing meta-analyses of the randomised trials included in the report and did not find significant reductions in mortality. Therefore, the experts couldn't conclude that these vaccines reduce mortality without also including the non-randomised studies in their deliberations. In contrast, for the DTP vaccine, they dismissed the non-randomised studies.

This is inconsistent and unacceptable, particularly because the results for the cohort studies for the BCG and the measles vaccines varied as much as those for the DTP vaccine.

There were other serious problems with the WHO report, which is surprising because two of the three authors were senior Cochrane researchers: The current Editor-in-Chief, Karla Soares-Weiser, and statistician Julian Higgins, who is editor of the 659-page Cochrane Handbook that describes how to do systematic reviews. They even used vote counting in the WHO report - how many studies are for and how many against? - which is a method recommended against in the Cochrane Handbook.

Peter has pointed out that the WHO uses the DTP vaccine as a marker for good coverage of vaccination in general. This should not happen. Programme performance indicators should be those that are known to be positively associated with increased child survival.

The WHO has not changed anything, and the Cochrane authors sacrificed sound scientific principles to help the WHO get off the hook, yet another Cochrane scandal.

Peter's findings are far more convincing than those in the WHO report. Interestingly, the Cochrane people later published their research in the *BMJ*, and this time, they provided meta-analysis estimates and reported that receipt of the DTP vaccine was associated with a possible increase in all-cause mortality, risk ratio risk 1.38 (0.92 to 2.08) and that the effect seemed stronger in girls than in boys.[1425]

# 13 Survival in an overdiagnosed, overtreated and overeating world

After I had published two books about why our prescription drugs kill people, I decided to write a book about how we may increase our chances of survival in a world that is dangerous because people are overdiagnosed and overtreated and overeat.[1426]

The first sentence in the book is: "You do not ask a barber if you need a haircut." Yet we willingly allow our doctors to subject us to various diagnostic investigations and treatments, which are not always necessary and can be harmful. I therefore advised that we must look up the evidence to protect ourselves against being harmed.

Doctors make many errors because they don' know better and because they use far too many drugs. I therefore wished good luck to patients who always let their doctor decide for them, as they will need it. Drug deaths are so common that, on average, a general practitioner kills one patient every year.[1427] They don't learn anything, as the causes are usually invisible to them. When, for example, a patient dies from a heart attack caused by an NSAID, the doctor doesn't know if the patient would have died anyway, without taking an NSAID.

Lethal harms can also be caused by infections, surgeries, Chinese herbs, electroshock, diagnostic testing, and admission to hospitals, which are dangerous places because of the many medication errors and other errors made there.[1428]

In the book, I work through many examples to teach people that it is often easier than they think to go on the Internet and find reliable information, which can give them confidence to sometimes ignore their doctor's advice. It is particularly useful to look up the package insert, e.g. by googling *package insert Lexapro*, to see if a drug is too risky to take, considering what the problem is. Quite often, it is best not to go to the pharmacy.

Simple searches often lead to useful results. For example, I searched *NSAID paracetamol back pain* on Google, and even though I did not add *Cochrane* as I often do, the second post was to a relevant Cochrane review, which concluded that NSAIDs were not more effective than paracetamol; they were not even better than placebo.[1429] In a matter of seconds, I had found sufficient information for decision making.

I started writing the book in 2017 at the swimming pool at a luxury hotel in Kalamata in Greece. People often say they go on holiday to relax but I wonder what this is. It is too boring for me to do nothing. So, why not write another book?

I published it two years later. It came out in seven languages and was well received by the newspaper *Politiken*,[1430] but not by Anders Beich, chair of the Danish Society for General Practice. He said it was full of outrageous claims, e.g. that kickbacks to doctors are common.[1431] I replied that I wrote nothing about kickbacks, only that doctors can expose us to diagnostic tests and treatments that can benefit them economically, which is correct.[1432] Furthermore, as everything in my book is well-documented, there are no "claims."

There is a big difference between being a free living, independent, drug-free, healthy citizen and being a patient. We should avoid the patient role as much as we can.

## Avoiding becoming obese and the oddity of veganism

We should avoid becoming obese. It shortens our life expectancy by several years,[1433] and it increases our risk substantially of getting diabetes, hypertension, and a lot else.

What inspired me to write the book was that, during our holiday in Greece, I noticed one morning that 9 out of 10 adults were overweight and that many were very fat. It wasn't

because of the sunshine. The fattest loaded their plates the most and refilled them. It was incredible how much they could eat. A Greek woman had about 70 small pancakes for breakfast with chocolate cream on the top of each one. It was heart-breaking to see the little fat children who would soon become equally big as their parents.

Most were Greeks, and they were not society's losers. I assume they had some self-discipline since they had managed their lives well, and that they chose to become obese because it increased their quality of life, at the cost of an increased risk of death.

Being obese is not a disease, but if fat people visit their doctors for other reasons, they might be prescribed drugs to lower blood sugar, blood pressure, and cholesterol. Such drugs are reimbursed. But I wondered if it is reasonable that taxpayers should pay for them. Some people become overweight because they have difficult lives and comfort themselves by eating, and some because they take psychiatric drugs. Yet, most obese people have no excuses. They just eat and drink more than they need.

Should we reimburse drugs that don't treat diseases but risk factors? Drugs lower the risk a little of untoward things happening, so you buy a kind of insurance against this, but no one reimburses the other insurances you have. And we all have risk factors for something. We might also consider that the drug industry, assisted by corrupt doctors, constantly lowers the bar for what is considered normal. We should raise that bar again and reimburse drugs only when the risks are considerable, e.g. when patients have a markedly elevated blood pressure or hereditary hypercholesterolaemia.

If low-risk people want to take drugs for their obesity-related risk factors, they should pay themselves. It is also far better to lose weight by eating less than to take drugs that reduce the quality of life. They can make you tired; cause muscle pain; reduce your sex drive; make you impotent and cause a lot else, which people may not associate with the drugs they take but believe are due to their advanced age.

Saying this is taboo. I am not on Facebook, but when I wrote about it in a newspaper,[1434] hundreds of hateful comments appeared on Facebook. And when I arrived at a golden wedding anniversary, rheumatologist Kjeld Christensen immediately attacked me on the doorstep saying he hoped my wife drove our car. Why? Because if I crashed, I would have to pay for the hospital costs myself. I could not convince him that my article could not be interpreted this way. Emotions often prevent people from thinking clearly, even though he and his wife were not overweight.

Some people can see the light I am trying to spread in the eternal pharmaceutical darkness. A patient wrote to me:[1435]

"My 67-year-old life was characterised by physical and mental health problems to such an extent that I asked myself if it was worth living at all. Your book (Deadly Medicines) meant that I have skipped my cholesterol medicine, half of my antihypertensive medicine and a few other preparations. I have changed my diet somewhat and I have switched from a doctor who didn't bother listening to the side effects to one who is not involved with any drug manufacturers. My blood pressure is even lower than before I started treatment. Most surprisingly, not only did I reduce the number of physical problems, but even the psychological problems I had accepted I had to live with totally disappeared a few days after I dropped my cholesterol drug. Even my short-term memory returned. And my cholesterol count is actually fine and even within the goals set by cholesterol hysterics. I now tell my story far and wide, also to doctors who often either raise their eyebrows and quickly change the subject or are simply indifferent. I have met with hospital doctors who have reaffirmed some of my experiences. But I still get angry at the pharmaceutical industry and its lackeys."

It is difficult to lose weight and maintain the weight loss. We should therefore avoid becoming fat. But if we fail and "eat in advance," as my wife called it when I took on six kilos during a vacation in France, what then?

Dieting is big business, and the advice is rarely evidence-based. But if you count your calorie intake and expenditure, put it in a spreadsheet, and ensure there is a deficit every day, you will lose weight. I have done that three times and as it worked, I have published the spreadsheet.[1436] When you get on the scale every morning, you are your own merciless judge, and succeeding becomes a kind of sport. If not, you won't succeed.

Certain food items have a surprisingly high calorie count, e.g. sweet biscuits, which you should stop buying. If you are offered a cake, take half as much as usual and enjoy it more. If you feel hungry in the evening and your stomach hurts, take a thin slice of bread.

After a few weeks, it becomes difficult. When you get slimmer, your basic metabolism drops, and you spend fewer calories when exercising. There are likely other counterbalancing forces at play. So, you might need to adjust the values on your spreadsheet.

I lectured twice at weekend courses in the USA for vegans about avoiding drugs as much as we can. In Santa Rosa, California, a woman asked me at the lunch table of my opinion of low testosterone, which I had never heard about. When I asked her what she meant, people laughed. Her husband was impotent, and she hoped testosterone tablets would help. It was a big issue there.

The participants were slim, which I understand, as it is uninspiring to eat only plants. It was difficult for me to get through these weekends on vegan food. When a man triumphantly told me, in Columbus, Ohio, that he had been a vegan for 40 years, I replied that I had eaten everything for 67. One morning, I told the whole crowd during my lecture how much I had enjoyed my two fried eggs, bacon, and a sausage for breakfast, and that, unless randomised trials had shown that veganism extended life by at least five years, I would never consider giving up eating what I liked.

I have experienced several times that there was a vegan among my guests who had not said anything about this peculiarity before we were all assembled around the dining table. I believe that vegan asceticism is sometimes overly obsessive and a kind of religious exercise of power over other people. Why don't they keep quiet so that they don't embarrass the host and just eat what they are served? This we call good manners.

After yet another embarrassment, I decided to study what veganism is. It is a total mess. Some people are lacto-ovo-vegetarians, others are lacto-vegetarians or ovo-vegetarians, some are pesco-vegetarians and eat fish and are therefore not vegetarians at all; pollo-vegetarians eat chicken; and pesco-pollo-vegetarians eat fish and chicken. Raw vegans only eat plants that have been heated to no more than 42 degrees, which is stupid, as they could die from bacteria or viruses in the food items. There are also semi-vegetarians (flexitarians) who mainly eat vegetarian food but sometimes choose meat. Even more bizarrely, some flexitarians add or deselect certain meat groups from time to time.

I got so annoyed that I wrote a newspaper article: *Dear vegans and vegetarians: Could you please be slightly more accommodating?*[1437] A cartoonist made my wife and me easy to recognise even down to the green T-shirt I was often wearing.

I say: "We have a little problem because Mette and Henrik have turned vegans, Rita is a pollo-vegetarian while Anne is ovo-vegetarian, and Mikkel and Tanja are now raw vegans, and then there are the Madsen's who are pesco-pollo-vegetarians."

Helle: “Can’t we just say we invited them for a glass of water? It is the thought that (counts).”

The dog: “I shall eat what is left over. I have no restrictions.”


Religious eating habits
Courtesy of Jyllands-Posten, cartoon by Rasmus Sand-Høyer

A big culprit in the obesity pandemic is sugar. In the 1960’s, the US Sugar Research Foundation wanted to deny sugar's role in heart disease and shift the blame to fatty foods. They sponsored research by Harvard scientists who published their review in the *New England Journal of Medicine* without disclosing sugar industry funding.[1438] They had cherry-picked studies that were critical towards implicating sugar as a cause of heart disease while ignoring similar problems in studies that found dangers in fatty foods. They concluded, without plausible evidence, that avoiding fat was "no doubt" the best dietary intervention to prevent coronary heart disease.

In the 1970’s, the US Sugar Association convinced the FDA to issue a statement that sugar was not hazardous to health. Conveniently, the chair of FDA’s committee was also the chair of the Sugar Association.

In 2015, it was revealed that Coca-Cola had cozy relationships with their sponsored researchers who conducted studies trivialising the effects of sugary drinks on obesity; and a candy trade association funded and influenced studies to show that children who eat sweets have healthier body weights than those who do not. Heart and cancer associations were also corrupted by sugar industry money.

In Denmark, the most renowned expert on nutrition, Arne Astrup, did a trial funded in 1990-94, which was not published until 2002.[1439] The giant sugar producer, Danisco Sugar, was one of the funders, and the trial showed that sugary drinks cause weight gain. In 1997, Astrup wrote a leaflet for Danisco where he claimed that sugar is not converted into fat, even though it had been known for decades that sugar can convert into fat.[1440]

Astrup has been a consultant for Coca-Cola and was chair of the Danish Council for Nutrition, a governmental agency. He was also on the governing board of the Global Energy Balance Network, which claims that sugary drinks and fast food are not the main reasons for

obesity. The network has received many millions in support from Coca-Cola,[1441] which has been very effective at selling their products to people living in the world's most rural and impoverished areas. In 2008, the company said that the Northern Territory in Australia was the most best-selling region in the world per inhabitant.[1442] Many aboriginals die young from diabetes and kidney failure. Coca-Cola must have shortened the lives of millions of people.

Sugar is everywhere and often in large quantities. In my local supermarket, I found these amounts: ketchup and barbecue sauce 24%; sweet mustard 32%; sweet chili sauce 51%; and sweet mango chutney 55%. Sugar is hidden in many products, where you would not suspect it to be, because they do not taste particularly sweet.

Sugar stimulates the same reward centres in the brain as nicotine, cocaine and sex, and, like the other stimulants, those kicks don't last long.

We have never had soft drinks in our home, only genuine fruit juice. And our children never missed them and didn't become addicted to Coca-Cola or other soft drinks.

A documentary showed a slim young man who began eating the rich, sugary diet many people eat, including breakfast cereals. He gained 8.5 kg in two months - even though he had not eaten more calories than usual and did not touch soft drinks, ice cream or chocolate.[1443] Thus, a calorie is not just a calorie; it depends on its origin. When he switched back to his normal diet, the kilos vanished, but he endured a period with abstinence symptoms.

In 2014, a TV documentary[1444] explored some of the world's diets. The Marshall Islands had the highest rate of diabetes-associated deaths in the world and one of the most overweight populations. Their inhabitants eat mostly canned foods from the USA. Mexicans have a free trade agreement with the USA. They consume a lot of soft drinks and are highly obese, like the Americans. I calculated that American adults weigh about 25 kg too much, on average, which corresponds to an additional 100 million Americans. Slimming America would make Americans happier and lessen global warming.

At the other end are the Nordic countries, France, Italy and Spain. France is particularly interesting because the French defy the usual dietary advice and enjoy fatty cheeses, fat poultry and beef; yet they are long-lived.

The conclusion seems to be that populations who do well have a minimal intake of processed food. The food and drinks industries are a serious threat to our health and regulating them could have dramatic effects on our obesity pandemic and our health.

In 2001, the Danish Board of Health launched the "Six a day" campaign. It was about eating fruit and vegetables, e.g. three apples and three large carrots every day. I am relaxed about what I eat and doubted our authorities had any firm evidence for their recommendations. Clearly, people who eat little fruit and vegetables differ in all sorts of ways from people who obsessively eat a lot of this.

The authorities did not reveal where their advice came from. But I found a meta-analysis of 95 studies.[1445] If people ate 800 g/day (e.g. 8 apples), the reduction in mortality was 31%. The authors concluded that 8 million premature deaths worldwide may be attributable to a lower intake, "if the observed associations are causal." That is exactly the problem. The observed effect could easily have been caused by bias. I wonder how many apples a day it takes to keep busybody epidemiologists away from our lives.

There is no quick fix for obesity. Most slimming pills were taken off the market after they had killed many people, sometimes after horrible suffering where people felt they were being slowly suffocated or were drowning.[1446]

One of the drugs that was taken off the market was praised in *New England Journal of Medicalisation,*[1447] sorry, they call it *Medicine*. The two authors did not reveal they were paid by the companies selling such drugs. They said the risk of pulmonary hypertension was small and outweighed by the benefits of the drug. However, the benefit was a trivial 3% weight loss. Moreover, the method used to estimate the final weight for all those who dropped out of the trials - carrying forward the last recorded weight – is highly flawed, as much of the weight people lose in the beginning comes back later. We showed that the last observation carried forward yielded a weight loss of 6.4 kg on topiramate versus placebo while baseline carried forward showed a benefit of only 1.5 kg.[1448]

Most importantly, a person's risk of something untoward happening is about the same after a trivial weight loss, and people taking slimming pills do not expect to be killed by them after horrific suffering.

In 2016, we published a review of the only slimming pill in Denmark using the clinical study reports of orlistat we had obtained from EMA.[1449] There were important disparities in the reporting of adverse events between protocols, clinical study reports, and published papers, which systematically understated the harms. What was published was unreliable.

Victoza and Ozempic from Novo Nordisk have been great commercial successes, but the company violated FDA rules and had to pay $59 million for its misdeeds.[1450] Novo also hired certified diabetes educators to act as salespeople and paid kickbacks to doctors.[1451] And Novo now claims on its homepage that "obesity is a serious complex chronic disease."[1452] It is not complex and it is not a disease.

## Alternative medicine is not an alternative

When I lecture about how dangerous our drugs are, I am often asked what the alternative is. It is no drugs. Unfortunately, people often find it difficult to do nothing, even though we all know that a good surgeon knows when *not* to operate. Practitioners of alternative medicine often think I am on their side because I am critical of drugs. That's not the case. I study the evidence and conclude accordingly.

Many patients and some doctors are attracted by the irrationality of alternative medicine, also called complementary medicine, with its pseudoscientific "explanations" of the supposed modes of action, which I assume is related to the propensity human beings have for religious beliefs.

Most definitions say that alternative medicine is not presently considered part of conventional medicine, which can be translated into: It doesn't work. If it did, doctors would use it and would not call it alternative.

When the editors of the textbook of internal medicine used by medical students in Denmark decided that a chapter was needed about alternative medicine, they asked me to write it, knowing that I had the skills to dissect the literature critically. After some years, they dropped it again, perhaps because the students had become more critical.

I looked for evidence of beneficial effects of the most used treatments but nothing I found was convincing.[1453] People can get very agitated if I gently tell them that I am not interested in discussing alternative medicine. It is like telling a religious fanatic that I don't believe in gods and don't want to discuss it. It's gasoline on their inner fire.

Once, at a private dinner, my tablemate was very tenacious and refused to accept my excuse that I knew too little about Chinese herbs to discuss them. I tried to start a conver-

sation with a woman next to me, but the stubborn man wouldn't let me go. He had no empathy whatsoever, let alone any modicum of politeness.

He ultimately played his trump card: "Don't you agree that Chinese herbs must be good for people, because the Chinese have used them for thousands of years?" I responded:

"They have also used bamboo as a building material for thousands of years. If I were an engineer, would you then tell me to use bamboo to build road bridges because the Chinese have used it for thousands of years?" It worked. The rest of the evening, he didn't look in my direction.

Herbal medicine is sometimes called natural medicine, but there is nothing natural about it. In the evolutionary battle for survival, many plants have developed toxins that are deadly also for humans.

Practitioners of alternative medicine rarely have a medical education or anything that comes even close. It makes no sense to make a diagnosis by looking people in the eyes (iris analysis), examining the patient's aura, recording the propagation of the vibrations from a tuning fork placed on the knee, or analysing the mineral content in a person's hair.

One of the stereotype criticisms of medicine is that it is reductionistic, whereas alternative medicine is holistic even though it offers the greatest simplifications. A wide variety of diseases are reduced to having singular explanations. Imbalances in clients' energy systems or small vertebral misalignments called subluxations in their spines get the same treatments, such as rubbing the soles of their feet, physical manipulations, or a homoeopathic remedy, no matter what caused the problem.

Some practitioners have psychological insight and may help clients with psychological issues, but that is due to their human qualities, not their use of weird treatments.

In 1964, US magician James Randi promised a reward of one million dollars to anyone who, under agreed-upon, controlled circumstances, could prove pseudoscientific postulates, for instance, the alleged mechanism of action for the effects of reflexology, homoeopathy, acupuncture and chiropractic healing. Over a thousand people have tried, yet all have failed, and the challenge was terminated in 2015.

People are often told that something is wrong with their energy systems; that they have a lack of certain minerals or vitamins; that they are being poisoned with something and therefore need intestinal cleansing; or that they need peculiar diets.

Cleansing is not needed, as the liver and kidneys handle toxic substances, and there is no good evidence that dental fillings with amalgam leads to health problems, or that some people suffer from multiple chemical sensitivities. I would rather say that many people suffer from multiple stupidities.

A common argument for using alternative medicine is that it cannot hurt. But we treat people because we hope to help them, not because we hope we won't harm them. Furthermore, alternative medicine causes a lot of harm and fraud is common. When patients at a dermatology clinic in England reported using herbal creams with good effect for atopic eczema, they were asked to submit the creams for analysis, and it turned out that 20 of 24 creams contained potent corticosteroids.[1454] Quite often, the opposite happens, that listed ingredients are missing.[1455]

Some ingredients are dangerous, which you can verify for yourself if you read textbooks of alternative medicine. Liver failure and deaths have occurred after ingestion of Chinese herbal tea containing wild germander.[1456]

Patients are often exposed to curious regimens with strict injunctions about what to eat and drink, or they are treated with mineral mixtures or large doses of vitamins, even though such regimens can be deadly.[1457]

Many alternative practitioners advise against highly effective vaccines. A survey showed that 31 of 77 homoeopaths and 3 of 16 chiropractors advised against giving one-year old infants a vaccination for measles, mumps, and rubella (MMR).[1458] Since they knew they were participating in a research study, their advice in their daily practices is likely even worse.

Chiropractors often take X-rays of the spine and declare they can see what is wrong. This is not correct. Many scientific studies have been carried out comparing X-ray films with clinical symptoms, and the correlation between the two is close to zero.

There are many trials and reviews, but a careful reading shows that manipulation doesn't work. In rare cases, it can result in stroke, disc herniation, or serious neurological deficits, and manipulation of the neck can lead to permanent paralysis of arms and legs. Deaths have also been reported.[1459] Forceful manipulation of the cervical spine involves that the practitioner grabs the head by the hands and suddenly swings it to one side. I once saw this done by a colleague. I was terrified and decided that under no circumstances would anyone be allowed to do this to me.

Many chiropractors offer bogus treatments. There is no rationale for suggesting that colic and sleep problems should be caused by subluxations, or that manual treatment of hay fever and asthma could be effective. However, the British Chiropractic Association made statements about childhood asthma, sleeping problems, otitis, colic, feeding problems, sleeping problems, and prolonged crying.[1460] The Association filed a lawsuit against Simon Singh because he called such treatments bogus treatments, and the judge accepted the lawsuit. Singh was convicted but appealed and it was concluded that he was entitled to defend his comments as legally permissible fair comment.

Massage has not been shown to have a convincing effect on anything. What is certain is that it is often painful, and yet the patients are supposed to be grateful. There are many reviews of massage, but the trials are small and of questionable quality.

Reflexology is based on the weird idea that massage of special zones on the soles of the feet can bring healing to sick organs. There is no proven effect of reflexology on any disease.

A craniosacral therapist website describes that the treatment is based on a rhythm, the so-called craniosacral pulse, which can be felt throughout the body. Such a pulse has never been found in studies of human physiology. Light touches, e.g. at the skull and its sutures, spine, and pelvis, are thought to relieve tension and blockages. A study claiming an effect on preventing and treating low-back and pelvic pain during pregnancy was not blinded, and the effect was too small to be clinically relevant.[1461]

Acupuncture is not effective either. Over a thousand randomised trials have been carried out, but the vast majority are of very poor quality. An astounding 99.8% of 840 trials of acupuncture published in Chinese journals reported positive results for the primary outcomes.[1462] This is because it would be very offensive for Chinese researchers to do a study that does not confirm the views held by their peers.[1463]

Many reviews of acupuncture trials are about diseases for which we would not expect needle pricks to have any effect, e.g. schizophrenia, artificial insemination, induction of labour, autism, myopia, glaucoma, depression, insomnia, ADHD, stroke, epilepsy, traumatic

brain injury, ischaemic encephalopathy in neonates, stress urinary incontinence, menopausal hot flushes, uterine fibroids, asthma, mumps, cocaine abuse, Bell's paresis, vascular dementia, smoking cessation, restless legs, and irritable bowel syndrome.

There is nothing “holistic” about these absurdities.

My research group did a systematic review of three-armed trials which had an acupuncture group, a placebo acupuncture group, and a group receiving no treatment.[1464] We included 13 trials and 3,025 patients with a variety of pain conditions. Inexcusably, the clinicians managing the needles were not blinded in any of the trials. Even so, the difference between acupuncture and placebo acupuncture was tiny, corresponding to 4 mm on a 100 mm visual analogue scale, which is clinically irrelevant (see page 225). Our demonstration that there are no clothes on the Chinese emperor raised criticism, which we rejected.[1465]

Acupuncture can be dangerous. During just one year, Danish authorities learned about four cases, including two children, where the needles had punctured the lungs, and one of the patients died.[1466]

There are several unconvincing reviews of healing - therapeutic touch - where the therapist enters a meditative state and passes the hands above the patient's body to find and correct any imbalances in a so-called vital energy field, the patient’s “life energy” or “chi.”

A Cochrane review of four trials of wound healing, all with the same first author, DP Wirth, was withdrawn because Wirth had committed fraud.[1467] It is doubtful if the trials were ever conducted, and Wirth perpetrated fraud, deception, identity theft, and other crimes for which he served prison sentences.

Divine intervention is where it gets most absurd. Distant healing includes prayer, and there is a highly embarrassing Cochrane review of intercessory prayer.[1468] We showed that the review goes beyond reason and uses an unsound mixture of theological and scientific arguments.[1469] It included ten trials aimed at testing if praying to a god can help those being prayed for. This idea involves three assumptions that are all extremely unlikely to be true: The existence of a god; that prayer can somehow travel in space and reach this god or works through a mechanism unknown to science; and that this god is responsive to prayer and can influence what would otherwise have happened.

The Cochrane authors ignored that a suspicion of fraud had been raised against a large trial, and that the largest “trial” was meant to amuse. They said that "outcomes of trials of prayer cannot be interpreted as 'proof/ disproof' of God's response to those praying," and that they attempted to quantify an "effect of prayer not dependent on divine intervention."

This is nonsense. Why would people pray to a god if an effect of prayer is not caused by divine intervention, and what would then be the causal mechanism? The authors provide no explanation, and it is hard to imagine how prayer for ill people located at the other side of the globe (as in one of the trials), and who were unaware that someone prayed for them, could have an effect without assuming divine intervention.

It is also hard to accept that a god would help Brian in bed A, because someone, after randomisation, was asked to pray for him, but not the less fortunate Paul in bed B. The authors contradict themselves when they say that their review focuses on people, "setting time aside to communicate with God," as the review is not about divine intervention.

They are also inconsistent when they note that, "If understanding of God is as limited as the Holy Literature suggests (1 Corinthians 13:12), the consequences of divine intervention may be considerably more subtle than could be measured in the crude results of a trial." If

that was a real concern, the authors should not have undertaken the review, because their reservation means that people doing trials of prayer cannot rely on what they observe.

Arguments like these are often used by practitioners of alternative medicine. They say that the research setup makes it impossible to study the real effect of their treatments. For example, they say that their treatments cannot be studied in randomised trials because the experimental setup destroys the effect. This falsehood is a perfect example of immunisation of the null hypothesis. The null hypothesis, which is that the treatment doesn't work, cannot be rejected. They also confuse randomisation with blinding when they say their treatments cannot be studied in randomised trials because they cannot be blinded. There are numerous trials of interventions that cannot be blinded, e.g. of psychotherapy and surgery, and we have learned a lot from these trials.

Regardless of the experimental results obtained, believers will be unaffected and will continue claiming with equal conviction that their treatments are effective.

Another statement also belongs to the realm of mysticism. The authors write that, "An omnipotent God would make concealment of allocation (of the participants to prayer or no prayer) impossible and may be noncompliant with the limitations of a randomized trial (Psalm 106:14,15, Job 42:2)."

Since a god could interfere with the experimental setup, it is difficult to understand why the authors excluded trials in which the treatment allocation was not concealed, and why they bothered to discuss the level of concealment in the trials they included.

The largest trial was published in *BMJ's* Christmas issue and was meant to amuse, as the trial evaluated the effect of prayer 4-10 years *after* the patients had either left the hospital alive or had died from their bloodstream infection. Thus, the trial evaluated the effect of retroactive intercessory prayer using historical data and its author argued that we cannot assume "that God is limited by a linear time." The Cochrane authors did not mention that the patients were randomised many years after their outcomes had occurred and did not discuss the likelihood that time can go backwards, or that prayer can wake the dead.

The retroactive prayer study reported a nonsignificant reduction in death for those prayed for but since it carried 75% of the weight in the meta-analysis in the Cochrane review, it led to a statistically significant effect of prayer.

Two years later, also in the Christmas issue, advocates for alternative medicine, prayer and healing tried to explain why the results of the retroactive study could be true using arguments from quantum theory.[1470] They took their arguments seriously, even though they were nonsense, which a physicist demonstrated a year later - also in the Christmas issue.[1471]

The Cochrane authors published this tautology: "A caring God may not wish to prolong suffering, so death therefore might be a positive outcome of prayer." This is a perfect immunisation of the null hypothesis that makes trials of prayer meaningless. If people survive, it is good for them, and if they die, it is also good for them.

Amusingly, as the review is characterised by delusional thinking, it was published in the Cochrane Schizophrenia Group. We informed the editor, psychiatrist Clive Adams, about the major problems, and he suggested we published a comment alongside the review, which we did. He assured us the review wasn't a joke, which only increased our amusement.

The review was updated in 2009 after we had criticised it, but the authors still included the study of retroactive prayer, justifying it with mysterious arguments. They called it a "relevant study," "not in jest," but "a rather serious paper." They also said that "retrospective prayer is practised by some people," and that the study was double blind since those praying did not know the outcome for any of the patients.

Perhaps they didn't, but as the outcome was already known for all patients, it is wrong to give a fake study bonus points for being "double blind." The Cochrane authors perverted the methodological principles without being aware they made themselves laughable.

On the possibility of waking the dead through prayer, they said: "Retrospective prayer may be considered theologically controversial, but we are not concerned with theology. Our aim is to review the empirical evidence for the efficacy of prayer as a treatment for ill-health rather than to consider questions of metaphysics. We judge ourselves bound to analyse the results of any trial that fits our original criteria (including our initial definition of prayer) and which is methodologically well constructed. Having set our protocol we are convinced that it would be unscientific to modify it to exclude a study that fits our criteria for inclusion."

This is dogmatic cookbook "science" at its worst. People are obliged to think even when they have a protocol. Otherwise, it is not science.

The review authors claimed they had found no evidence that the study was a jest. This is also false. The author of the retroactive prayer study explained it was a jest,[1472] and we noted in our comments that we got the same answer when we contacted him.

It is a scandal that Cochrane has not withdrawn this ridiculous review.[1473] It is a pillar of shame for Cochrane, but well, they have so many, so one less can be just the same.

I recommend everyone who is inclined to believe in gods to watch *Life of Brian*, which is the most elegant satire about religions ever made. It brings religions down to earth where they belong, as they are man-made. It starts with the three wise men entering the wrong house when they want to seek out Jesus, who has just been born. They end up in Brian's house and he becomes a religious leader, much against his will.

"Always look on the bright side of life," sings Brian, after he has been crucified. I have a cartoon where the prophet Muhammad lies on a couch next to a psychiatrist up in the sky and complains: "Other prophets have followers with a sense of humour."

Homoeopathy is also weird. It is held that infinitesimally small doses must be used, which means that the patient might not ingest a single molecule. Homoeopaths believe that preparations leave some sort of imprint in the solvent[1474] - in other words, that water can remember what it once contained.

A 12C dilution means that the material is diluted by a factor of $10^{12}$. This corresponds to dissolving the substance in all the world's oceanic water. 30C dilutions are recommended for most purposes, which corresponds to dissolving the substance in a cube of water with sides far larger than the distance from the Earth to the nearest galaxy.

Homoeopaths believe that a higher dilution has higher potency and are stronger and deeper acting. This is bogus, and doing placebo-controlled trials of homoeopathy is equally insane as doing trials of intercessory prayer, as we compare nothing with nothing.

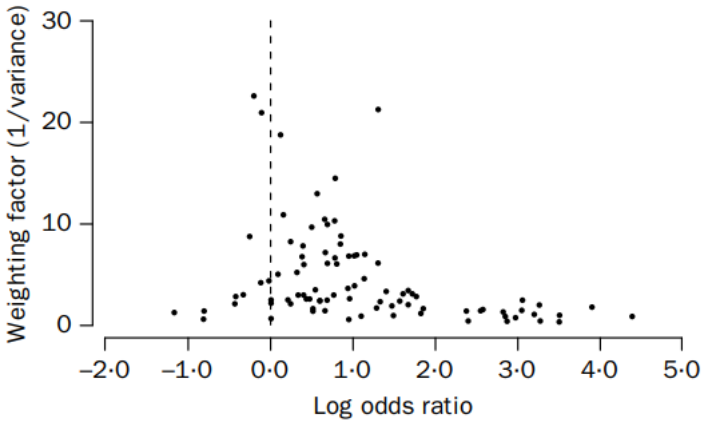
Nevertheless, a 1997 meta-analysis of 89 trials in *The Lancet* reported a large effect, an odds ratio of 2.45, in favour of homoeopathy.[1475] The authors concluded that the effects of homeopathy were not due to placebo.

Four years later, other researchers looked at the same trials and published very different results in the *BMJ*.[1476] The treatment effects were much larger in small studies and if published in languages other than English. There was no effect in the largest trials. In 2017, another review confirmed the huge bias and the lack of effect in the most reliable trials.[1477]

Insanity has no limits. A homoeopathic pharmacopoeia exists and in 2006, the UK drug agency allowed the manufacturers to state what indications their products have, with no requirements to demonstrate effects in randomised trials. Homoeopathic remedies were

offered through the National Health Service despite protests from doctors. The Minister of Health declared that the effect could not be demonstrated in ways required for conventional medicine. Prince Charles, now King Charles, is an outspoken advocate for homoeopathy and this likely played a role. It is difficult to earn a knighthood if you go against royalty.

Some investigators might have added an active drug to the homoeopathic solvent to make sure it worked, or they could have fabricated the data, which I suspected for several of the trials because the benefits were extremely large. The graph for the effects in *Lancet* was extremely asymmetrical, suggesting large-scale fraud (see the figure, the biggest trials are at the top, and the biggest effects are to the right):




In 2003, I held the annual festive lecture for our deceased Queen Ingrid at Åbenrå Hospital, *What is the value of our treatments?* I was carefully instructed about what I should do; was told that Queen Margrethe II always read the lecture afterwards;[1478] and that the lecturers always received an order. I was not offered one. Likely because I told the audience, among many other examples, how foolish homoeopathy is. My integrity is not for sale.

The European Union also contributed to the folly. In 2011, the European Parliament's agriculture committee agreed to spend two million Euros on investigating if cattle, sheep and pigs could benefit from homoeopathy.[1479] Critics pointed out that animals cannot benefit from a placebo effect because they will not understand they have received a treatment. This raises an interesting issue: Every time homoeopathy is prescribed, a patient is deceived, which is unethical.

There is another reason why homoeopathy is unethical: It leads to serious harms. It is licensed in some countries for treatment of specific symptoms, which might encourage patients to avoid seeing a doctor. When homoeopathic remedies are seen as real treatments, patients might be putting their lives at risk.

In 2006, the *BBC* visited Britain's biggest manufacturer of homoeopathic remedies with a hidden camera.[1480] The journalist said she planned to go to Malawi - a high-risk area for malaria - yet the shop suggested garlic, oil of citronella, and vitamins. The adviser told the journalist that the homoeopathic compounds would protect her: "They make it so your energy doesn't have a malaria-shaped hole in it, so the malarial mosquitos won't come along and fill that in." Sheer gobbledygook, typical of the way practitioners of alternative medicine "explain" things.

*BBC* also revealed that some homoeopathic pharmacies claimed their products could treat malaria in lieu of antimalarial drugs.[1481] Homoeopathic pharmacy websites have many

products with indications, e.g. homoeopathic replacements for vaccines against measles, mumps, and rubella, and homoeopathic pills for hepatitis, tuberculosis, and typhoid.

Sometimes it is the other way around, that homoeopathic remedies contain too much of a substance. In the USA, several babies died, probably because the biggest manufacturer of homoeopathic remedies put too much of the deadly nightshade, *Atropa belladonna*, in its "teething" tablets.[1482]

In 2017, a seven-year-old Italian boy died from an ear infection that had spread to his brain.[1483] The family's homoeopath discouraged the mother from using antibiotics even though the condition worsened and advised her to continue with the homoeopathic treatment. A doctor on call advised that the child should go to hospital immediately. But even when he was in critical condition, the family refused to give him antibiotics. He went into coma and died three days later. The parents were charged with manslaughter.

Homoeopathy has never been popular in the Nordic countries. Only 1% of Danes take a homoeopathic remedy[1484] whereas in France, it is 36%.[1485] In the UK, there are homoeopathic hospitals in the National Health Service, and in several European countries, homoeopathy can be studied at universities. In Germany, thousands of medical doctors have formal qualifications in homoeopathy.

Why can't we combat this stupidity? Too many people are swarming for the occult and irrational and deposit their common sense somewhere where they cannot find it.

Humans have a peculiar taste for nonsense, including the supernatural. Astronomer and physicist Carl Sagan wrote a whole book about it where he mentioned, for example, that polls had shown that most Americans believe in the Devil's existence and that we are being visited by aliens in UFOs.[1486] A scientist of his acquaintance dryly remarked that, "If the aliens would only keep all the folks they abduct, our world would be a little saner."

In the United States, many billions of dollars have been wasted on research in alternative medicine. In Denmark, it was a political initiative to set up a centre, VIFAB, to review and do research in this area. The centre was closed 15 years later because nothing of substance had come out of the investment. We were told that various alternative treatments lacked scientific support - which we already knew - or we received wrong messages, for example that homeopathy works for children with ADHD, which was a double negative. Homoeopathy cannot work for anything, and ADHD is not a disease (see page 153).

Nonsense about the "secrets of water" was propagated on national Danish TV in 2019 under the heading *Nature, Science, and Technology*.[1487] In the programme, it was claimed that water flowing past a closed container of "Grander water" extracted from a mountain spring in the Alps can render the water more orderly and a better cleaning agent. The miraculous alp water, which was sold in a household version for the miraculous sum of €1,000, defies the second law of thermodynamics, which states that the entropy (the degree of disorder) in a closed system will always increase with time unless you add energy to the system.

Some Germans claimed that with the power of thought you can influence water in a closed container several thousand kilometres away. This was "documented" by graphs that ran roughly in parallel until people started thinking about the container.

Science is under attack. It is not helpful that publicly financed national TV stations publishes nonsense under the guise of scientific credibility.

# 14 The fall of the Cochrane empire

The Cochrane Collaboration was a highly successful, idealistic grassroots movement in its first two decades and it was very stimulating for me to play a key role in this (see page 58).

However, in 2011, Cochrane started to decline morally when a new director for the UK Cochrane Centre - ear, nose and throat specialist Martin Burton - arrived. I published a book about Cochrane's demise in 2019,[1488] which I updated in 2002, and shall only summarise the most important issues here.

Burton was the only centre director that most of the other directors disliked. In contrast to us, he was pompous and often interjected in the discussions despite not knowing much about the issues, and he had psychopathic traits.

Although he was a newcomer, Burton didn't try to find out what we expected of him, what our common culture was, or what his current staff was doing, before he rushed into action. When he sent an outline of his plans, we were shocked. He would wind down the centre's research programme and replace it with what he called a programme of research in "Learning and development and engagement." We had no idea what that was, and there was other newspeak.

He also planned to get rid of two-thirds of his staff and alienated them from day one. They would all be fired before Christmas and could then re-apply for their jobs.

## Cochrane's new CEO, Mark Wilson, a fatal mistake

In 2012, it became even worse. The Cochrane leadership committed a fatal mistake by employing British journalist Mark Wilson as Cochrane's new CEO. The centre directors, apart from Burton, became nervous about what was going to happen. The Steering Group wanted the centres, which were highly independent, to be managed by Wilson, arguing that they had more business functions than scientific functions. We spoke out vociferously against this. Several directors were highly respected for their science and their skills were essential for their centre's survival because they obtained funding for projects that had nothing to do with Cochrane activities, but that allowed them and their staff to do Cochrane work.

I had three additional arguments. First, centres were responsible for offering workshops for people wishing to do Cochrane reviews, and if the lecturers are not active researchers and skilled methodologists, these workshops would be substandard. Second, if Cochrane centres were perceived as businesses and not hubs of scientific excellence, it would be impossible to recruit good people. Third, it would be more difficult to obtain permanent governmental funding.

Angry emails were exchanged between centre directors from mainland Europe and the USA, and I arranged a two-day strategic planning meeting for continental European centre directors in Copenhagen in January 2013. We did not want Burton to come but invited Wilson for the second day as we hoped to get on good terms with him and influence him. However, he was highly manipulative right from the start and postulated we had agreed on something we had not agreed on. It was typical of Wilson that he had a different perception than others about what was agreed; a difference that always worked in his favour. When he didn't get what he wanted when he negotiated with people, he returned one to two months later and postulated the exact opposite of what was said and agreed upon. He tried to make

people doubt their own memories of the events by being aggressive and manipulative, or by tampering with meeting minutes.

We were so upset that the German director, Gerd Antes, participated in our email discussions leading up to the meeting although he was on holiday, trekking in Vietnam.

Wilson's brutality was obvious. He didn't care about others and embarked on his path to obtaining supreme power and control over everything in Cochrane, even over people who struggled to survive and gave Cochrane a lot for free. He declared that the Cochrane IT team of eight people, who worked in my centre, would no longer be managed by me but by him although I contributed most of the funding.

Wilson's thirst for power and admiration was unsatiable. He deleted "Collaboration" from our name to the chagrin of many people, including Cochrane's founder, Sir Iain Chalmers, but it fitted well with the fact that it wasn't possible to collaborate with him. You could only obey orders.

To celebrate Cochrane's 20th anniversary, Cochrane's leadership asked science journalist Alan Cassels from British Columbia to write a book about Cochrane. He interviewed many people during the annual colloquium in 2011 in Madrid but in February 2013, He wrote to Tom Jefferson and me that he considered us the most trusted people in Cochrane and wanted to share the bad news with us first. Wilson had killed his book saying he should have been much more critical of my work and that "there was too much Peter Gøtzsche" in it. Iain was mentioned 160 times; I 30 times and Tom 17 times. Wilson wasn't mentioned, which must have hurt his narcissistic feelings.

Tom and I had contributed a lot to Cochrane, and Alan had written a book about the most essential events in Cochrane's history, not about those with the most shoulder stripes.

To get the book out, I offered economic support, but Alan found another publisher.[1489]

Wilson destroyed Cochrane systematically and transformed a prosperous democracy into a tyranny. He reduced Cochrane to a mediocre organisation where some of the smartest people who had been key to Cochrane's success left after having been harassed because they were seen as "difficult" or shadowed for the Great Leader. Many people were afraid of him, and he was in total control of the Governing Board.

Directors or other key people in 9 of the 12 oldest Cochrane centres conveyed to me that they were unhappy with the way Cochrane headquarters dealt with them. French Cochrane Director Philippe Ravaud sent a damning complaint to the Steering Group in 2015 stating unreservedly what most of us thought, and the reason he dared speak out was that he announced his resignation at the same time.[1490] Philippe called the Cochrane Central Executive Team (CET) "power-hungry technocrats"[1491] who saw Cochrane centres as their pawns or low-skilled employees.

Philippe's team had developed translation software specific to Cochrane materials and had translated over 10,000 abstracts into French. But, behind his back, Wilson had set up a project for translation of Cochrane reviews with Philippe's partners. Wilson used his ideas, considered himself competent for all decisions, and allocated human and financial resources to himself. He asked Philippe to use software that was costly and inefficient, which meant that his team of 20 volunteers was reduced to one in less than 6 months. As usual, the CET assessed themselves, and Wilson told the Governing Board that the translation project progressed very well. It was not the tool that was inefficient, it was the way Philippe managed volunteers!

Wilson introduced a huge bureaucracy and many indigestible policies that stifled academic freedom and put unproductive burdens on us. His long documents were impossible to

remember or interpret, and some were contradictory, which is typical for managers that cause upheaval and leave everyone confused when they move on to "new challenges," before people realise, they have been fooled. He paralysed the Governing Board with all his papers and bullet points, and one of the members, Nancy Santesso, said: "Mark shows up with his 50,000 papers and when someone says … 'but that's doesn't make sense'… nothing actually gets changed."

Quite often, important documents about controversial issues where centre directors were strongly opposed to his ideas, were sent out one to two days before meetings and we were then asked to make a decision, without having had time to check the issues. The Memorandum of Understanding, a very important contract between centres and Wilson, was sent two days before the meeting, and another crucial document was sent for approval in mid-July when most of the directors that had been involved in the work were on holiday.

Wilson stepped into centre directors' territories without their permission; without informing them; without responding to them when they brought it up; and continuing not to copy them on essential emails even after they had complained about this transgression of Cochrane rules. He didn't listen and overruled people who were more knowledgeable than himself about local circumstances and people. He fundamentally misunderstood the purpose, goals and essence of Cochrane as a charity, or didn't care.

With his dictatorial manners, Wilson created catastrophes, political chaos and other damage in many countries. When I had worked carefully on establishing a branch of my centre in Russia for some time, one of Wilson's staff suggested to a person that he should help set up and coordinate a "Russian project." However, this person was once centre director for a Russian branch of my centre that I needed to close due to serious irregularities, which involved selling bits of Cochrane reviews illegally to a publisher. When I found a good candidate, Wilson corresponded with her without copying me.

In Sweden, the intrusions of Wilson and his staff led to chaos, which it took me a while to disentangle. They wrongly assumed that a trouble-maker who had contacted them was a key person and they didn't even have the courtesy to ask me if this was correct before they went into action and messed up everything. When the Swedish branch had been registered, Wilson, who had had nothing to do with it apart from his screw ups, presented a video[1492] with himself on the Cochrane webpage where he gave a little talk about how pleased he was that there was now a Cochrane centre in Sweden. He congratulated the new Swedish director several times but said nothing about my role in establishing the centre. He never gave credit to people he didn't like, no matter how great their achievements; he ignored them, or punished them. By the end of his talk, he regretted he could not come to the opening of the centre. He wasn't invited.

On several occasions, Wilson favoured people who were corrupt, wanted to benefit themselves, or had nothing to do with the initiatives centre directors had embarked on, which it took a lot of work to remedy. He is by far the worst leader I have ever encountered. He didn't care that he repeatedly violated the written agreements he had made with centre directors. Every time I told him he had violated the rules he had himself constructed, he reacted with anger. Once, when I pointed out in writing that he had stepped into my territory without my permission and knowledge, he just didn't reply. Worse still, the co-chairs of the Governing Board didn't reply to my ensuing complaint.

Wilson was good at playing the game: Pretend there is a problem, solve the non-existing problem, and get credit for your excellent leadership skills. He was also good at lying. He tried to justify his hostile takeover of my IT team by saying at a centre directors' meeting

that the team was in crisis. This wasn't true, and Cochrane contributors had always valued their work highly.

We had run into problems with Cochrane headquarters also before Wilson's arrival. In 2008, an external consultant produced a report about whether IT development could be done cheaper by using commercial providers. The report was highly misleading and caused a great deal of agony. It was an important reason why the leader of our IT team since 1996, Monica Kjeldstrøm, left her position at the centre three years later. She noted that my centre had contributed financially four times as much as the Cochrane Collaboration to the IT team over the last 12 years. Given this, we wondered how Cochrane headquarters, even in their wildest fantasies, could think it might be cheaper to use a commercial provider.

It took over a year and involved lawyers on both sides to accomplish Wilson's hostile takeover of my IT department, for which my hospital had absolutely no sympathy. They encouraged me to seek economic compensation, but as none was granted, it was a kind of theft. Wilson took what I had built up over 19 years without even thanking me for my colossal contribution to Cochrane, neither personally, nor officially, e.g. on the Cochrane website. The Steering Group co-chairs, Lisa Bero and Cindy Farquhar, wrote to me that, "the structure cannot remain fixed because of one individual," as if I had stood in the way of progress. The takeover was harmful. It increased costs, as I stopped contributing financially, and Cochrane now had to pay rent to Rigshospitalet, too.

As soon as the takeover had been accomplished, in April 2015, the IT team leader, Jessica Thomas, was callously fired during a Cochrane meeting in Athens. She was deeply shocked. According to Danish law, the dismissal would have been illegal, as she had received no warning. Two highly valued IT specialists were presented with such poor offers and treated so badly by Wilson's staff that they left for much better paid jobs. One of them was highly dissatisfied that his previous job experience didn't count for Wilson. This was not the case when two other IT staff were employed under Wilson's leadership. Under Wilson's rule, some were more equal than others, as George Orwell dubbed it in *Animal Farm*. The two IT people who left described Cochrane's Human Resources department as a "disaster." There were no negotiations about salaries; it was "take it or leave it." Several of the remaining IT staff told me they were unhappy with Wilson's leadership, and that much of what he said didn't make sense to them.

When Wilson had been in office for a year, the *Canadian Medical Association Journal* noted that, "Eyebrows may rise when the realization kicks in that someone with no health care experience is now leading one of the foremost organizations dedicated to ensuring good clinical decisions."[1493]

My Nordic Cochrane Centre was the largest in the world and one of the most successful ones, but Wilson took credit for what I and others had achieved and hunted me down right from the start when he took office in 2012. He didn't understand what science and scientific freedom is about and didn't care either but was obsessed with branding and marketing, as if we were a drug company.

The way Wilson haunted me was related to his taste for censorship. He invented a totally foolish Spokesperson Policy that no one could understand, as it was internally contradictory. He claimed over and over that I had violated it, which I never did, but his approach was Kafkaesque in all its grotesqueness. He even dictated that I, as the only person in the whole Collaboration, was not allowed to use my centre's letterhead although this was the only affiliation I had, as I worked full time for Cochrane.

Wilson disliked intensely my much-acclaimed book about organised crime in the drug industry.[1494] This was curious, and as many of the things Wilson did were bizarre and difficult to understand, journalists wondered if he had powerful friends in the drug industry and was perhaps planted in Cochrane to destroy it?

Psychiatrists quickly found out, and took advantage of it, that Wilson punished and humiliated me publicly, whenever they complained about me and my use of my centre's letterhead. In March 2014, the Danish Psychiatric Association attempted to character assassinate me and almost succeeded. They wrote to the two Cochrane groups dealing with schizophrenia and depression complaining about my newspaper article two months earlier about psychiatry's ten harmful myths (see page 198).[1495] They asked: "How do you, with the specific knowledge you have on antipsychotics and antidepressants, respectively, evaluate Peter Gøtzsche's statements as presented in his article. We would be very pleased if you would take up the task of making such an evaluation."

It wasn't the task of Cochrane to evaluate what I had written. But Wilson, deputy CEO David Tovey who was also Cochrane's Editor-in-Chief, and the two co-chairs of the Governing Board, Jeremy Grimshaw and Lisa Bero, replied: "Cochrane is treating very seriously the points you raise concerning comments made by Professor Gøtzsche on the use of psychotropic medication. I want to state explicitly that these are not the views of The Cochrane Collaboration on this issue and we do not endorse them."

The inadvertent use of "I" shows that Wilson wrote the letter, which Grimshaw confirmed. The first draft was even worse. Wilson noted that my article was part of my promotional work related to my book about organised crime, which was not correct.

I wasn't consulted on his response and didn't even know what was happening. I was in a jungle in Panama with my wife, Helle, surrounded by birds, tarantulas, caimans, monkeys, butterflies and sloths, with little contact to the outside world.

I had no chance of defending myself. The psychiatrists celebrated their kill by reading aloud Cochrane's letter at the Danish Psychiatric Association's annual meeting.

The news that my own organisation had denounced me ran amok in the Danish media. Journalist Ole Toft from *Altinget* broke the story.[1496] He stated that I did not have support

"for a number of controversial statements about the drug industry and the use of psychiatric medicines," which other journalists uncritically repeated.[1497] Toft even fabulated that "the organisation doesn't agree either with the views Peter Gøtzsche describes in his book where he compares the business model of the drug companies with criminal organisations." This was free fantasy, and I did not present "views." I documented in my book that Pfizer had been convicted of organised crime and that other companies did business the same way.

Journalist Klaus Larsen wrote in our medical journal that Cochrane emphasised that my "accusations" against the pharmaceutical industry and my comparison with organised crime were not in accordance with Cochrane's views.[1498] I had not presented "accusations" but facts in my book and Cochrane's leadership had not mentioned organised crime at all.

In my newspaper article, I noted that psychiatrists base their practice on myths that are harmful to the patients, and that many of them are aware of this but don't dare deviate from the official positions because of career concerns. I therefore wanted to come to the rescue of the conscientious but oppressed psychiatrists and patients by listing the worst myths and explain why they are harmful.

Wilson had stated in his letter that the views contained in my book were not the views of Cochrane. This comment showed that he was beholden to the drug industry. How could he have other views than mine on the drug industry, which he knew very little about? And why did he want to protect the industry instead of the patients? Why did he mention my book, which the psychiatrists hadn't done? Obviously because he planned to get rid of me.

Another sentence in Wilson's letter was also not a response to an issue the psychiatrists had raised: "We will be asking Professor Gøtzsche to share with Cochrane colleagues any unpublished data that is not yet publicly available, so that it can be incorporated objectively into new or existing Cochrane Systematic Reviews as appropriate; and then be seen and evaluated by you [the Danish psychiatrists] and other specialists in the field."

This totally inappropriate remark was designed to undermine my position as an independent and highly respected scientist. I was not surprised that a journalist at *Politiken* interpreted this as meaning that I had now come under Cochrane censorship and wouldn't be allowed to publish anything unless it had been approved by Cochrane headquarters.[1499]

On 28 March, I wrote to Wilson and the co-signatories that their letter to the psychiatrists was the "biggest disaster in my twenty years with Cochrane. My reputation is in ruins because of your letter. It doesn't matter that my book is evidence-based and has 900+ references. All that matters is that, because of your letter, which you omitted to discuss with me before you sent it, everything I have built up is in ruins. If you had contacted me, which is a rule we have always followed, this disaster would not have happened. People in Denmark are disturbed by what you have done to me and my centre."

I met with Wilson, Tovey, Grimshaw and Bero in Panama City just before our official meetings started. Grimshaw apologised that they had not consulted with me before they sent their letter. Wilson did not apologise but just stared at me with his hateful, killing look, which is so scary that I can still see it in front of me today.

They published a letter in *Altinget* saying they had been misunderstood, backpedalled and contradicted what they had written to the Danish psychiatrists.[1500] They now claimed they neither supported nor rejected my interpretation of the evidence about the drug industry and the use of psychiatric drugs. They criticised Ole Toft saying, "We have not at any time expressed any opinion about Gøtzsche's views on drug companies." Really? They wrote to the psychiatrists that "The views contained in this book are also not the views of Cochrane."

My repair work was endless because journalists and others continued to refer to the press coverage in 2014 as "proving" that no one needed to take my scientific articles and evidence-based books seriously because my own organisation has denounced them.

Journalists love witch-hunts, particularly when a well-known person is the target, and the press propagated half-truths and full lies. Being a journalist, Wilson knew this would happen.

Two people complained to Cochrane about the way they had disavowed me. Wilson explained that the mere listing of an affiliation does not mean that someone is speaking on behalf of the affiliated institution, which was window dressing because, for me, this principle was suspended. Wilson *always* interpreted my affiliation as speaking on behalf of Cochrane, and he turned a blind eye to others in Cochrane, including his own staff, when they did the same thing.

The minutes from the centre directors' meeting in Panama were highly critical of Wilson's behaviour: "There was general agreement of the principle expressed by Peter that the co-chairs, the CEO and the Editor-in-Chief, and their staff, should not communicate with national institutions, authorities or others in matters that could be potentially damaging without first consulting with the responsible local Cochrane Centre or Branch Director."

During the rest of my time with Cochrane, Wilson routinely violated this decision. The only reason why the centre directors dared go against him was that he had only been CEO for 1.5 years. He had therefore not had enough time to take full control over the centres and to tamper with their meeting minutes.

It was scary to see how journalists distort their stories when they smell blood. I felt like the senator in ancient Rome who said that people would not succeed stabbing him in the back, as he had so many scars already that the knife wouldn't get through. Not a single journalist admitted they had misrepresented Wilson's letter.

I published various rebuttals, including *The Cochrane feather that became five hens*,[1501] which refers to one of HC Andersen's famous stories about how rumours become established truths when they are repeated often enough.

It didn't last long before Cochrane leaders came after me again, likely ordered by Wilson to do so. In May 2015, I gave a talk at the Maudsley debate in London and explained in the *BMJ* that long-term use of psychiatric drugs causes more harm than good and that the drugs should be used very sparingly.[1502] I had informed my Cochrane colleagues in advance as a courtesy, but my kindness was not returned. The same day my article appeared, Cochrane's Editor-in-Chief, David Tovey, and the three editors in charge of the three Cochrane mental health groups, attacked my scientific credibility on *BMJ's* website:[1503]

"We are concerned that the picture painted by Professor Gøtzsche may be a partial one, and that the extreme recommendations he makes based on his interpretation of the published research are inappropriate, and insufficiently justified by the scientific literature presented, to guide decision making in practice or health policy."

My colleagues stabbed me in the back instead of asking me about the issues they were concerned about, which were all thoroughly documented in my psychiatry book that came out four months later.[1504] Several editors of other Cochrane groups told me they were dismayed that the four editors had denigrated my research and my professional prestige by appealing to their authority. A news channel got it right: "Unable to counter Gøtzsche's arguments in any rational or scientific manner, organized psychiatry, and, alas, members of the Cochrane Collaboration itself, have disgraced themselves with suspiciously speedy and mendacious denigrations of his work."[1505]

The Cochrane editors' rapid response appeared in *BMJ* even before the Maudsley debate was over, and psychiatry professor Allan Young used it his final remarks during the debate, which was recorded,[1506] but the chair did not allow me to respond. Young claimed that my *BMJ* paper had been rebutted by the Cochrane editors, which was false and could not be the case, as my position was based on solid scientific evidence while the Cochrane editors' reply was evidence-free and opinion based.[1507]

I alerted the *BMJ* to the fact that Young had not declared his ties to the drug industry. Medical journals normally publish a correction when an author fails to declare his conflicts of interest, but this didn't happen. The *BMJ* protected Young by inserting the missing conflicts into the text of the paper instead.[1508]

To defend my reputation, I wrote in *BMJ* that journalists and others had interpreted the Cochrane editors' denigration of my research as a thinly disguised attempt at protecting psychiatry's guild interests, and some even suspected that they also tried to protect the drug industry. The Cochrane editors did the patients a great disservice, but Wilson forced me to publish an apology on *BMJ's* website and threatened to close my centre if I didn't. He even demanded I wrote something I disagreed with.[1509]

Tovey is a doctor and his views on my work were very different to Wilson's. He wrote to me two weeks after the *BMJ* debate that "We do not differ anywhere near as much as you think." He had read my book about organised crime and had recommended it to many people and he acknowledged that the benefits of psychotropic medicines had been systematically overestimated and the harms underestimated. He also realised that the brevity of my article did not permit me to make the case sufficiently strongly. He hoped that we would get a chance to discuss this in a friendly and mutually respectful fashion when we met.

This message confirmed my suspicion that Tovey was ordered by Wilson to attack me. These two people are as different as Dr. Jekyll and Mr. Hide.

A Canadian bioethicist whom Tom Jefferson and I call the good Mark Wilson to separate him from the bad Mark Wilson, sends mass emails around that are very enlightening, as many people contribute. He wrote to me that Cochrane's public criticism of my work and not getting in touch with me privately reflected that "They want you out and are shooting Cochrane in the foot in the process." He added that if they did not wake up and stopped attacking me, "I suspect it would not only be their foot that they will be shooting." This was prophetic.

In September 2015, I wrote an invited article for the *Daily Mail* noting that psychiatric drugs are the third leading cause of death.[1510] The editor made many changes and insisted that I added this statement: "As an investigator for the independent Cochrane Collaboration … my role is to look forensically at the evidence for treatments."

Even though my article came out two weeks after I had published my first psychiatry book where all the evidence was, my research was publicly denigrated by the Cochrane leaders.[1511] They said my statements about psychiatric drugs and their use by UK doctors could be misconstrued as indicating that I was conducting my work on behalf of Cochrane. They also said that my views on the benefits and harms of psychiatric drugs were not those of the organisation.

This was the third time I was in an infight with my own organisation about psychiatric drugs in just 18 months. Obviously, Cochrane as an organisation cannot have any "views" about psychiatric drugs that carry more weight than those of a researcher who has studied the research in detail. But Wilson's tactic of disavowing my evidence-based conclusions worked, of course. Five days later, *BMJ* published a news item, *Cochrane distances itself from*

*controversial views on psychiatric drugs*.[1512] It is not controversial that scientists tell the public what they have seen. They are expected to do exactly that, without censorship.

When Wilson uploaded his personal attacks on one of Cochrane's highly respected researchers on the Cochrane website, it had a chilling effect on everyone, fearing public humiliation. During Cochrane's Annual General Meeting in Wien shortly afterwards, Tom Jefferson asked the Cochrane leaders[1513] why they had published this statement.

After Lisa Bero had replied, I said that I had not violated the Spokesperson Policy and that it was abundantly clear that I spoke on my own behalf in the article. I noted that the policy says that how you declare that you speak on your own behalf is subject to cultural variation and that you should not hide that you come from Cochrane. I gave historical information that I had derived my expertise from my Cochrane work. I asked if public denigrations of my work benefited Cochrane or not and said the drug industry was thrilled about them.

Carl Heneghan, Director of the Centre for Evidence-Based Medicine in Oxford, said that Cochrane's actions towards me were very damaging. If Cochrane doesn't like what you say, you will get a renunciation on the website. Nobody wants to risk that. Carl also said he was confused as to whether Cochrane was still a collaboration and asked if "Collaboration" could be brought back into the logo.[1514]

Wilson encouraged those who had dissenting views to make them known, to stand for election, and to continue to hold the leadership to account. But, as Carl and Tom recently noted, the Collaboration was over.[1515] Those who stood for election and tried to hold Cochrane to account were ridiculed and sidelined: "In 2018, Peter Gøtzsche was sacked from his position as an elected Board member and lost his Cochrane membership. Why? He pointed out the 'organisation's shift towards a commercial business model approach, away from its true roots of independent, scientific analysis and open public debate.'"

Grimshaw said that there had been some harm done and provided support to my freedom of speech, noting I was one of the founders of Cochrane and one of the world's greatest methodologists.

Tom ended the discussion by asking: "Can we all just agree that people like Peter are welcome in the Collaboration? … We are what we are because of people like that. And the contribution that nobody speaks of that Peter made was the opening of the regulatory assessments.[1516] Thanks to him, his obstinacy, his Nordic Cochrane Centre and the Ombudsman. Can we all agree on that, please?" Big applause. The Cochrane leaders looked uncomfortable.

The sad fact is that Cochrane did not welcome my success with EMA, and they did not take any initiatives but considered it a nuisance that it was now possible to do much more reliable reviews of drugs, as it would mean more work for Cochrane authors.

In June 2016, Wilson harassed me again after my group had complained to the EMA over the way the agency had handled the suspicion that the HPV vaccines might cause serious neurological harms (see page 278). Julie Wood, Wilson's associate, wrote to me that two people had requested a clarification if this was official Cochrane policy. She claimed I had broken the Spokesperson Policy because we had caused confusion as to whether our views were official Cochrane views, and she added that "It is such a shame we are now in this unnecessary position, and I find it disheartening that we are back in this same position again."

I asked Wood for the requests, and it turned out that the senders were not confused. I replied that I wondered why she had asked me to rectify the situation as soon as possible, as there was nothing to rectify.

Wood became one of the many staff members that didn't last long under Wilson's tyranny. It was yet another non-issue that Wilson faked into being an issue he could use to attack me. I told Wood that our letter to EMA was not about a Cochrane-related issue and couldn't possibly cause any confusion. I also wrote that I found it bizarre that the Cochrane leadership told me not to use my centre's letterhead or my title for official letters: "My job description includes an obligation to share knowledge with the rest of society, including participation in public debate, which the letter to the EMA is an example of."

I provided some comments from Heneghan that underlined why we must change the Spokesperson Policy from being an instrument used to punish Cochrane collaborators publicly to one that tells people to stop asking silly questions of the Cochrane leadership, the answers to which they know already before they pose them.

I reminded Wood that she had written to me that Tovey and herself had reviewed our letter to EMA and were sympathetic to our arguments. However, she had asked me to add a disclaimer to our letter to EMA, even though we had already sent it and it was out in the public domain. I told her that the CEO's office should issue a statement in support of our letter and that if they were not prepared to do this, "I think a public explanation is required, as people might wonder why it is not in Cochrane's interest to support a well-documented letter coming from a Cochrane centre that points out that the European Medicines Agency is doing substandard work when it comes to protecting public health."

Wilson ignored this. He didn't give a damn about the patients but went all in to accomplish his character assassination of me. But as he was on holiday, the two co-chairs of the Governing Board, Lisa Bero and Cindy Farquhar, replied. They agreed with me and told the complainants that we were free to send comments to the EMA and had used our correct affiliations. They also suggested the complainants raised their concerns in a public forum, so they could be transparently discussed, which they did (see page 286).

This was exactly how Wilson should have responded to all the inappropriate complaints about my use of my Cochrane affiliation. I was so fed up with Wilson's attacks that I consulted with several people, including the German Cochrane Director, Joerg Meerpohl. I wanted to publish a disclaimer on our website, so that Wilson could no longer hunt me down: "Statements made by people employed by or affiliated with the Nordic Cochrane Centre do not represent official views of the Cochrane Collaboration as an organisation, unless this is explicitly stated. They represent the interpretation of the science or the views of those people who make them."

Wilson rejected my proposal and told Joerg that he should not have engaged with me but should have referred me to himself as my line manager. This was abusive. Centre directors were free to consult with whomever they liked, including other directors.

After Wilson had returned from his holidays, he, Wood, and the co-chairs wrote to me that I had broken the policy, without a single justification! Facts meant nothing to Wilson, which is how tyrants operate. Everyone but me was a puppet to Wilson.

The fact that the co-chairs allowed Wilson to overrule their correct decision, for no good reason and without any evidence in his support, demonstrated that it took Wilson at the most only four years to break the control Cochrane's Governing Board was supposed to have over him. In the binder the Board received from Cochrane's law firm for use in Wilson's show trial against me in 2018, the letter where the co-chairs declared no wrong-doing on my behalf had been omitted by Wilson's loyal ally, co-chair Martin Burton. This fraud was deliberate, as I reminded the co-chairs in April 2018 that the letter was important for my case.

In January 2017, Wilson declared I had broken the Spokesperson Policy again, in relation to a programme on Irish National TV (RTE) about the HPV vaccines. He argued I should have used my university affiliation and criticised that I had written letters of complaint to the RTE and the Broadcasting Authority of Ireland (BAI) using my centre's letterhead. Wilson even complained that since I had used the letterhead in my "personal capacity and not as the Nordic Cochrane Centre" this "would still lead RTE and the BAI to assume that the complaint is coming from the Nordic Cochrane Centre and not you personally."

This was totally bizarre. The complaint *did* come from the centre, as I was its director, and I represented it and was interviewed as such. If I could not represent my centre, who could? And I was not interviewed about a personal issue but about our science, which was carried out at the Nordic Cochrane Centre. Moreover, Wilson contradicted his own policy, which said "we should be transparent about associations with Cochrane."

The Irish journalist had a hidden agenda, which was to discredit the scientific work we were doing on the HPV vaccines. There was nothing I could have done to prevent her from calling me the director of the Nordic Cochrane Centre.

Later in 2017, when we tried to find out why so many young people with schizophrenia had died so young in a Norwegian study (see page 165), a key investigator, Ingrid Melle, asked me: "Since you are writing with a Nordic Cochrane Centre letterhead, I'm curious if Cochrane has any plans for doing anything in this area?" This inappropriate comment seems to have been part of a concerted effort aiming at removing me from my job.

The US Stanley Medical Research Institute did not reply, but psychiatrist Edwin Fuller Torrey, its associate director of research, complained about me in two letters to Wilson. He wrote that my objectivity was "very much in doubt" because I was Protector of the Hearing Voices Network in Denmark. He claimed that this organisation promotes the belief that "hearing voices are caused by trauma in childhood, for which there is no solid evidence," and he concluded that, therefore, he would not find any Cochrane publication on mental illness to be credible. He also said that the Network encourages people to stop taking their medication, and that, "It is very difficult to imagine how anyone with these views could possibly be objective regarding a Cochrane study of antipsychotics, thus impugning your credibility which is your most important asset."

This was pure evil. How can my objectivity be "very much in doubt" when I inquire about deaths and their causes? Furthermore, contrary to Torrey's assertions, solid evidence shows that psychosis is related to childhood traumas, with a clear dose-response relationship.[1517] Torrey drew the logically false conclusion that because I am Protector of the Network, no Cochrane publication on mental illness is credible.

Instead of dismissing Torrey's follies, Wilson wrote to me that I had broken the Spokesperson Policy and that this would reasonably lead any reader to assume that the request was from the Nordic Cochrane Centre and that the views expressed were those of the centre. Which they were.

Wilson wanted to apologise to Torrey for "any confusion in this regard." Quite interesting, that one bully wants to apologise to the other bully when the person between the bullies has done nothing wrong.

The setup was ridiculous. Cochrane's own hired lawyer didn't find I had broken the Spokesperson Policy at any time,[1518] and he concluded in his "confidential" report, which I have uploaded in the public interest,[1519] that the policy was too ambiguous to be accurately interpreted.

Such trifles don't matter for tyrants, and Wilson invented a fake problem. My views were even shared by my staff, and my letter was not a public announcement, but a letter to a funder. No one could become "confused."

Ryan Horath, a lawyer and IT expert from Chicago, described Wilson's actions this way, after I had been expelled from Cochrane in September 2018:[1520]

"Cochrane leaders became obsessed about Gøtzsche using Nordic Cochrane letterhead … JESUS CHRIST, WHAT IS WRONG WITH YOU PEOPLE. A researcher is making inquiries about the suppression of information regarding children who died in a clinical trial and everyone is worried about what letterhead it is written on? … it is clear the outrage over use of Cochrane letterhead is feigned outrage, as this was a private letter ... That is how kangaroo courts operate."

About the report by Cochrane's lawyer, Horath said that "Despite being clearly written in a biased manner in favour of the board, it is damning for the board … If the Centres are to act autonomously, then they necessarily need to be able to use their letterhead for business they feel is part of their work ... restructuring around a centralized structure is a disaster for a collaboration of scientists."

In another analysis, Horath noted that Cochrane behaved like a communist party:[1521] "When one faction gains control of the party, competing factions are asked to resign or forced out of the party … This board will not approve any investigation into its actions. Authoritarians never do."

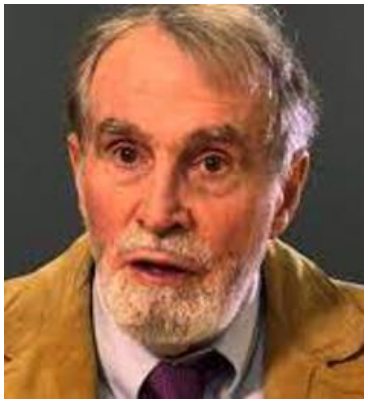
One month after my expulsion from Cochrane, Bob Whitaker published the article, *The Cochrane Collaboration has failed us all*.[1522] He explained that Counsel – Cochrane's lawyer - in his report, praises me for the rigour and quality of my academic work, and as an academic of very considerable eminence, whose scientific work is of the very kind that burnishes the image of Cochrane as a first-rate scientific organisation. Bob mentioned the letter Wilson wrote to Torrey in March 2018, where he threw me under the bus:

"A director of the Cochrane Centre wants to find out more about the deaths in a long-term study of psychotic patients, and the CEO of the Collaboration, rather than finding that pursuit worthwhile, finds reason to think it might provide cause to expel the director from the Collaboration … You would think that all members of the Cochrane Collaboration would be red-faced upon knowing of this exchange … [Cochrane] needs to remember that it serves the public, and this decision to oust Gøtzsche fails to fulfil that obligation."

In early 2018, two years after the court case in Holland where I defended a mother who had killed her two children in a psychotic state caused by a depression pill (see page 147), Anton Loonen, who supported the prosecution, suddenly attacked me again. He submitted a complaint about my use of my centre's letterhead, which was vexatious and should have been treated as such by Wilson. Loonen also asked whether my centre endorsed my expert report, and whether my conduct was in line with Cochrane's policy on conflicts of interest.

I replied to Wilson that I had addressed a lawyer on behalf of myself and that my expert report had not been made public. Given that I was approved as expert witness because of my work at the Nordic Cochrane Centre and I served as its director, I found it natural to use its letterhead, and even if I had written my report on blank sheets of paper, my affiliation would have been obvious.

As usual, the Wilson robot declared that I had broken the Spokesperson Policy.



Edwin Fuller Torrey

Anton Loonen

As I wanted to change Wilson's catastrophic course towards Cochrane's collapse, I ran for a seat on the Governing Board and was elected in January 2017, with the most votes of all 11 candidates. This illustrated the widespread dissatisfaction with Wilson's leadership, as I was the only candidate who questioned his actions and suggested better alternatives. In my election statement, I did not pull any punches:[1523]

"People have wondered why so many of our resources go to salaries of centrally employed staff and they worry that volunteers may stop contributing their time for free when they see that people with similar tasks get a salary ... the more employees … the more work they will create for themselves and others, which might not always be productive ...

Our brand has no value of its own but derives its value from our research. Some centre directors have argued strongly against the CEO's idea that it should no longer be a priority for centres to carry out methodological research or to be strong in research and thereby be good examples for others to follow ... Without research being at the top of our agenda, our organisation might lose its ability to attract top researchers and it might also have negative implications for the willingness of governments to support Cochrane centres financially …

One issue that has come up repeatedly is: Should the CET [Central Executive Team] decide on what centre directors should be doing when it doesn't provide their salary and when the centres are on government finances, which come with expectations that might not always coincide with what the CET would want? I believe we need to avoid that too much decisive power becomes concentrated at the CET and, if elected, I will work on refocusing on our central values and aims ...

If we asked the public whether they are happy that our current policy states that up to half of the authors on a Cochrane review are allowed to have financial conflicts of interest in relation to a drug company whose product is being evaluated, I am pretty certain what the answer would be. We are here to serve the public and I therefore feel we should be more outward-looking when we make policies ... What does the public want from us? …

I believe Cochrane reviews generally have become too detailed, too cumbersome to carry out, and too difficult to read. In some reviews, there are more than 50 different outcomes, and the authors dutifully analyse and report all these outcomes despite the fact that we know that outcome reporting bias is very common, not least in published reports of drug trials. If elected, I would advocate simpler reviews, with much fewer outcomes that focus on what is relevant and important for patients. A difference on an elaborate, composite scale rarely says much about whether the patients' lives have improved, particularly not when side effects are regarded as a separate issue and are very often downplayed or omitted altogether from published trial reports."

Cochrane had become highly ineffective due to its obsession with detail. I suggested already in 2005 that Cochrane reviews should be much simpler and address fewer outcomes.[1524] Some Cochrane reviews had results section that were longer than 5,000 words, and that was still the case 12 years later.

My vision went directly against virtually everything Wilson stood for. But I was supported by many influential people, for example:

Iain Chalmers, Cochrane's founder: "Your election statement is great ... Best wishes in promoting the progressive agenda you have outlined."

Jim Neilson, former Steering Group co-chair: "I strongly agree with your concerns about the change of culture in the Cochrane Collaboration … You have my vote. Good luck!"

Andrew Moore, Cochrane editor: "Many congratulations. I agree that there are dangers ahead with the current direction of travel. Your views reflect mine. It would be terrific if there were reasons to engage, rather than considering disengaging."

Paul Garner, Cochrane editor: "I think you will be much more effective than Corbyn [Labour Party leader] in the UK! Onward!"

Wilson was not thrilled that the only person who criticised him received the most votes, and he likely ordered the Board not to disclose the voting results to the public. I reminded them that Cochrane was supposed to be an open and transparent organisation and ensured the votes became known.

After I had been elected, I persuaded my good friend David Hammerstein to run for the board as an external member, and he was elected, too. David is very intelligent and had a huge political experience from his work in the EU Parliament (see page 114). He could have been a tremendous asset for Cochrane but was "too big" for little Wilson to handle.

At David's first board meeting, in Cape Town in September 2017, co-chair Martin Burton took him aside with no witnesses and told him that five board members wanted to kick him out and that if he didn't withdraw voluntarily, an emergency meeting would be set up to remove him before his assignment became officially announced one or two days later.

David refused, and several board members became very angry about Burton's intervention. The board had elected David and, although I was the one who had persuaded him to volunteer despite his many other commitments, Burton did not even inform me about his secret manoeuvre, which was a sign of a totally sick culture at the top in Cochrane. It had caused great distress on several occasions, when a co-chair, Burton or Bero, took board members aside, one by one, including me, with no witnesses, trying to convince them that they should do otherwise than they had planned.

While we were in Cape Town, board member Catherine Marshall sent a letter to the board where she complained about David and me in a highly derogatory fashion, using *ad hominem* arguments. David responded politely that, "It is a serious mistake and could be very negative for any organization to shift discussion from substance and content to psychology or personal styles. It often reflects a great resistance to openly discuss policies and to consider any substantive change, personalizing the issues instead of debating them with arguments ... It is usually not advisable for the cohesion of a group to label certain points of view (usually in agreement with the status quo) 'wise', 'professional', 'positive', 'legal' and 'collaborative' while disqualifying other opinions. This is not usually the way to promote an enrichment of an organization with new information and ideas."

David and I should have resigned from the board after these experiences, as it was so obviously dysfunctional and hostage to petty gripes from members who refused to debate issues on their merit. Wilson's grip on power was just too strong to change.

After Cape Town, I published a short piece about what it was like to be on the Governing Board.[1525] I noted that Nelson Mandela was a great moral leader and that my vision for Cochrane was that it would become the world's moral leader in a healthcare dominated by politics and conflicts of interest: Cochrane must incessantly point out the need for a better world where clinical trials are not designed, carried out and analysed by those who have direct financial interests in the outcomes, and where the data are no longer manipulated or hidden if they do not please sponsors. I also wrote: "Up to now, Cochrane has been close to invisible in a political context. This should change. We could be a strong political voice."

How naïve I was. With Wilson as CEO, Cochrane was the opposite of a moral leader.

I thought I could achieve much-needed changes as an elected trustee and that I would acquire some immunity towards Wilson's attacks on me. I didn't. It became worse because I was now a threat to Wilson's dictatorship. He hated me intensely right from the beginning and developed his master plan early on for the final solution of the Gøtzsche question.

A month after my expulsion, Helle wrote to me while she was at work:

"You are not the problem but the symptom of a sick organisation that no longer promises democratic rules of play. Which, due to lack of vision and intellectual power, has shut itself down, and perceives it as persecution and harassment when someone who is much more visionary and able to do things they cannot do themselves, constantly steps on the sore toes. Mark Wilson and his management team have ended up in the wrong place.

The Peter Principle of being promoted until the level of incompetence fits so well with the whole management and Wilson. He is a little bookkeeper who does not understand his organisation at all, and he ends up navel-gazing with a feeling of being persecuted by everyone who can do more or see more than himself. He has assembled a team around him that cannot cope either with their tasks.

Then you need to get rid of the wisest, so that you may again appear to be an oracle. It is so embarrassing. Cochrane was created by those who can now no longer be involved. As things are currently, it is light years better to be outside than inside an organisation that focuses on image, brand, and output, because anyone with a small exam from a business school can figure this out."

Wilson wrote many ridiculous documents including a 93-page edict, *Brand guidelines*,[1526] which Horath commented on.[1527] He explained that Cochrane's "brand" was largely built by the centres. And then the new management, which had no moral authority, told the centres how best to build the brand they had already built while at the same time providing almost nothing back to the centres: "I think the centres see the relationship as parasitic and one-sided, and I cannot blame them. A corporate power structure does not work for a scientific organisation like Cochrane. Dissenting voices are squeezed out, not respected. A corporate structure is exactly what powerful interests like pharmaceutical companies want at Cochrane. Because corporations will move quickly to remove people they deem controversial. Eventually you are left with subservient people who fill out the forms and publish the work without asking the difficult questions. Many studies are already produced in a check box manner, where companies are sure to cross off every technical requirement while producing a biased design that results in the desired outcome. Their ideal world would include a Cochrane that produces meta-analyses the same way. Check off all the boxes. Do not ask any difficult questions, just publish the free marketing materials."

Horath's analysis was razor sharp. Cochrane acts exactly as he described it, even today.

The little bookkeeper wanted us to set targets according to his strategic plan, and he wanted to tell us what to do and to report back to him whenever we changed anything in

our plans during a calendar year. It was micromanagement in the extreme. Wilson required ludicrous targets like the number of guidelines issued by the National Board of Health we would influence, which was beyond our control. We may set a target about how many times we will help ducklings cross the road with their mother, but if there are no ducklings, we will miss our target.

During a meeting I had with Wilson in 2015, he said: "I was very unhappy about your report for the Nordic Cochrane Centre." I wrote in my report that most of his items were not a priority for us and that we therefore did not have targets for them. They were *really silly*. The embarrassing system was later abandoned, but as always, I was punished for having been more visionary than our Great Leader.

I explained to Wilson that, some years ago, we had many targets in our strategic plans but we realised they weren't helpful for our work. It was much more important to be flexible and innovative and to grab the opportunities as they arose.

Wilson was outright hostile, particularly when I said that I was not a bookkeeping type of person, but a pioneer who broke new frontiers all the time. Perhaps he was jealous. I don't know. He had very little self-insight.

Wilson criticised that very few people turned up at our workshops about how to do Cochrane reviews. It didn't move him the least that many people attended our workshops earlier and that they were now so good that they held their own workshops, or that we had published an extraordinary number of Cochrane reviews, compared to the size of our country, which I had written an article about in the *Cochrane Library*. In 2021, I discovered that my article from 2011 was gone, and I therefore uploaded it on my website.[1528] I showed that Cochrane centres were essential for review production. As Wilson had systematically undermined the centres to consolidate his grip on power, I suspect he removed my article.

Wilson said it wasn't good for Cochrane that I bathed in blitz light about other things than marketing Cochrane reviews. I couldn't convince him that my international visibility and influence meant I gave a lot of good publicity to Cochrane even when the journalists weren't interested in those Cochrane reviews Wilson's unit press released and put spin on.

Being a journalist, he should have appreciated this, but he was too dumb. I talked about academic freedom and the impossibility of fending off journalists who wanted to report on our research, which was often ground-breaking. Should I say, "Sorry, I cannot talk to you, as this is not about a Cochrane review?" I also told Wilson that I could not employ good people if their work was only about marketing Cochrane reviews.

I felt Wilson tried to bomb me back to where I started my career, as a drug salesman in the drug industry, which was very humiliating. He wanted me to sell Cochrane reviews, no matter whether they were good or bad, just like when drug reps sell pills. He was a small-minded little man with grandiose thoughts about himself. It was my misfortune that the most horrible person I have ever met was my boss.

When I said that my book about organised crime in the drug industry had sold 4,000 copies in just the first eight weeks in its German translation, Wilson looked very uncomfortable. He didn't congratulate me, just sat with his stone face staring at me, which he always did when he was unhappy. He was very, very creepy.

Already at my first Governing Board meeting, in Genève in April 2017, I experienced how corrupt Cochrane had become under Wilson's leadership. I suggested to introduce a complaints procedure which ensured that the person complained about had an opportunity to

respond before the Cochrane leadership took any action. Wilson - who always participated in the meetings - was vehemently against this and was involved with writing the minutes. The board ended up approving minutes they knew were untruthful in a way that benefited Wilson's views, although they were unfair and not shared by the board.[1529]

I have to say that this reminded me of Hitler. His generals dared not tell him that he was wrong, and people who opposed him or called for a fair process were either killed immediately or slowly in a concentration camp.

The mismanagement ended in total chaos, after three months of hefty email discussions. And the Charity Commission rules were violated: "The minutes should record exactly what was agreed, particularly for important or controversial decisions."

As I was worried that Wilson might tamper with the minutes, I sent my own minutes to the board the same day we had discussed this issue. As the minutes were untruthful, I wrote again and noted that I found it outrageous that the minutes said that "the manager is not obliged to share all material from the complainant with that individual." We never discussed or accepted this Russian version of a fair process.

Several board members made similar observations to mine. Marshall did not recall any reference to "Cochrane's Charter of Good Management Practice" at the meeting and was surprised to see it included in the minutes. She noted that we had agreed that the person should see the complaint and be given the opportunity to comment.

I wrote that the co-chairs, Bero and Farquhar, by their manipulations, had shown a remarkable lack of respect for the other board members. They responded that, "We are happy to be criticised for missing some of the detail of the discussion, but I do not accept that they were misleading or inaccurate." I asked if it was Wilson who was the "I" in this sentence but got no reply. This was the second time, the word "I" revealed that Wilson was in total control and that the co-chairs were his puppets.

Despite all our efforts, the minutes related to this item continued to be false, and after 2.5 months of deadlock, Lucie Binder, Senior Advisor to the CEO, asked the board to approve the overall minutes for the whole meeting. The next day, the Austrian Cochrane Director, Gerald Gartlehner, protested that the minutes reflected issues we had not discussed, and he was supported by the German Director, Joerg Meerpohl.

Bero wrote that she was deeply disturbed that the board "is considering making a change in policy based on the personal experience of one of our board members." This tactic was familiar to me. I was the messenger for everything that was wrong in Cochrane and was Cochrane's scapegoat. I replied that, "It was NOT a question about complaints about me, it was a general question that addressed senior people in Cochrane. The co-chairs try to make this a personal matter, which unfortunately is a common management strategy when managers face trouble because of their own actions and try to put the blame on others."

Gerald supported me and noted that, 70 years ago, Austria and Germany had a justice system that used exactly the approach described in the minutes. Accuse people of wrongdoing and not provide the complaint material to them, denying the accused the opportunity to properly defend themselves. He also emphasised that this issue was not about me but about a general principle of fair treatment and justice.

The co-chairs responded that they had heard from board members who were disturbed by Gerald's email. "We need to keep our correspondence civil. We are taking this matter seriously and will deal with this off-line with Gerald."


Gerald Gartlehner


Joerg Meerpohl


Nancy Santesso

Ironically, this was exactly the type of behaviour Gerald warned about. Big Brother is watching you and will take action, with no witnesses. The co-chairs gave themselves more authority than they had. Deputy Canadian Cochrane Director Nancy Santesso and I found Gerald's point civil. I wrote that if a scientist invents something that didn't happen and writes about it, we call it fraud, and the minutes contained bits that didn't happen.

I also noted that I considered Binder's voting procedure illegitimate, as voting cannot make right what is obviously wrong. I recommended the board to read Kafka's novel *The trial* and some of Dostoevsky's novels about secret processes and added: "We are highly sensitive to such tendencies in Europe, given our recent history."

The co-chairs could no longer handle the chaos Wilson had caused by the untruthful statements he had inserted in the minutes. They declared that "This matter is closed ... 7 people voted in favour of the revised minutes … Therefore, the minutes … were approved."

For the historical record, I uploaded the many email exchanges in Appendix 6 to my report to Cochrane's lawyer.[1530]

Gerald and I requested that our comments be included in the minutes, but they continued to be seriously misleading and conveyed the impression that only two people had objected to them, although five board members were highly critical.

In my comments to the minutes, I had noted that "It was not agreed that the complaint should not be disseminated to the media, posted on blogs, social media, etc. In my view, irrelevant complaints that have not been submitted in good faith should sometimes be exposed when the case has been dealt with, just like we expose cases of scientific fraud." I also noted that we did not discuss or agree that "The manager does not have to disclose … emails between individuals of Cochrane who are investigating the complaint."

We had discussed the New Zealand Principles of Natural Justice, and the board was sympathetic to these. I therefore asked them to be added to the minutes, but the co-chairs refused to do this.

Considering what went before, the final minutes from the Governing Board only time - where Wilson was not allowed to be present - in Genève were ridiculously brief and misleading: "5. Correspondence. Discussion about correspondence relating to Peter and his work. Peter agrees to follow the Spokesperson policy."

Wilson demolished the pluralism and democracy we had in Cochrane and turned it into a dictatorship where he behaved like the rulers in Orwell's *1984*, with their Ministry for Truth, which Wilson in Cochrane called "Trusted evidence." We were all forced to have this in our letterhead:

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A man who was widely distrusted and was a habitual liar talked about trusted evidence. The irony cannot be greater.

## Cochrane on industry payroll

In the early days of Cochrane, some doctors took their bad habits with them and obtained funding from drug companies for their Cochrane activities. Some reviews were even sponsored by the company whose product was being evaluated.

During the Cochrane meeting in Melbourne in 2003, Drummond Rennie, co-director of the San Francisco branch and an editor of *JAMA*, said that industry funding would be a catastrophe for Cochrane and destroy its credibility.[1531] In contrast, rheumatologist Peter Tugwell, a member of Cochrane's Steering Group, was comfortable with company funding and argued that Cochrane might not survive without industry support. Drummond and I said that if Cochrane could not survive without industry funding, it should die.

Six months later, I proposed a prohibition on industry sponsored reviews at the Cochrane Colloquium in Barcelona. This was the only time I was ever invited to give a plenary talk in Cochrane. I have listened to numerous talks that were politically correct and terribly dull. In 2021, I asked Tom Jefferson if he had ever been invited to speak at a plenary session at a Cochrane Colloquium. He had not and he had always found that the various speakers were like people coming from another planet.

A Spaniard was supposed to argue in favour of industry funding, but he was so busy with praising his Latin colleagues that there was no time left to say anything. It was farcical.

I had fought vigorously against industry funding ever since Cochrane started in 1993. It was a lonely fight, apart from Drummond's support. Once, he turned up at a meeting on the other side of the globe and explained, "I am here to protect you against yourself!"

When I brought the issue on the agenda for our centre directors' meeting in Providence in the USA in 2005, the discussion became heated and unpleasant. We agreed that there should be no direct funding of Cochrane Centres or branches by commercial sources, but as usual, Cochrane moved with tortoise speed and industry funding of centres was allowed for another five years!

Very little happened the next seven years, but in 2012, Cochrane researchers on Novo Nordisk payroll created problems. One of my PhD students worked on a Cochrane review of diabetes drugs when he discovered that Novo had left out deaths in their publications that were listed in the clinical study reports. He published this serious omission in the *BMJ*,[1532] but the Cochrane researchers' only concern was that his article might influence their good relations with Novo. This spoke volumes about why we needed to be clean.

A month later, I reminded the co-chairs of the Steering Group, Jeremy Grimshaw and Jonathan Craig, of a report I had sent ten months earlier where I provided a detailed criti-

cism of our Commercial Sponsorship Policy, which was unclear, outdated by many years, ambiguous, and difficult if not impossible for Cochrane's funding arbiters to work with.

I noted that several people outside Cochrane had contacted me with their concerns that the policy sent a bad signal to the outside world and offered to draft a new policy. I said the issue was urgent and, as I had been the driving force nine years earlier in Barcelona for getting industry funding out of Cochrane, I asked to become involved in the redrafting of the policy and called for a firm deadline.

The co-chairs' reply was typical of Cochrane: "With a policy as important as this one, you would appreciate the need for appropriate consultation and debate throughout the organisation." This could have come from a manual for politicians about how to stall unwelcome proposals that would reduce their level of corruption. Were 19 years of waiting - since the foundation of Cochrane in 1993 - really not enough?

They revised the policy, without my help, and it was still highly embarrassing. I was not surprised that Wilson, at the meeting I had with him in 2015 in Copenhagen, didn't understand why I had criticised our Commercial Sponsorship Policy. He never expressed any criticism of the drug industry. Not a single time in six years. I therefore dared not say anything about industry funding at my first Governing Board meeting, but at the second, in Cape Town in 2017, I suggested to change our policy so that no one with financial conflicts of interest would be allowed to become author on a Cochrane review that evaluated that company's product.

The board was very positive towards my simple proposal, but co-chair Cindy Farquhar was not. At one point, I left the room and went to the toilet to cool down a little because she treated me very rudely when she argued why I should not be involved with my own proposal. Despite this, I was asked to draft a proposal for a new policy, which took me an afternoon. I explained that the existing policy contradicted Cochrane's statement that "Cochrane Reviews must be independent of conflicts of interest associated with commercial sponsorship and should be conducted by people or organizations that are free of such bias." The policy allowed Cochrane authors to have financial ties to the manufacturer of the product being reviewed provided there were more authors who did not have such conflicts.

My demonstration that Cochrane contradicted itself was not well received by co-chair Martin Burton. He immediately started the Cochrane behemoth machine and sabotaged my work. Already the next day, he effectively prevented anyone from writing to other board members that they liked my proposal, and he claimed that we had agreed that I should:

"Propose a process for how we are going to move forward. Who will we consult with, in what order, over what timescale? How will we get input from the community? How will we gather information about the pros and cons of changing the policy and how will we evaluate the potential impacts of changes?"

I believe Burton lied. I have a good memory and we had not agreed to this. The whole board, apart from the two co-chairs who acted on Wilson's orders, were happy that I had offered to redraft the policy.

It took the board two months to agree on a process for reviewing the policy.

Twenty months after I had redrafted the policy, a progress report was circulated.[1533] But almost two years of hibernation was still not enough. It said that Cochrane could not implement a policy that eliminated conflicts of interest, but that everyone "should be confident that our policy is robust and in-line with industry best practice. In addition to instilling confidence in our users, we must find a way to continue to allow people from diverse academic, clinical, and cultural backgrounds to contribute to the production of Cochrane reviews."

This unadulterated bullshit was short for, “We still want the industry money.” And in line with industry best practice? Industry does its best to corrupt influential doctors!

Over two years passed before the world saw the ground-breaking result of Cochrane’s elaborate processes. In December 2019, Cochrane’s Deputy Editor-in-Chief, Karla Soares-Weiser, announced Cochrane’s “new, more rigorous ‘conflict of interest’ policy.”[1534] So, what was that exactly? “The proportion of conflict free authors in a team will increase from a simple majority to a proportion of 66% or more.”

It took Cochrane 16 years to arrive at this “rigorous” policy after I had pointed out in Barcelona that a better policy was needed. The HealthWatch Newsletter had a saying headline: *Cochrane policy change raises eyebrows*:[1535]

“Dr Peter Gøtzsche was a co-founder of Cochrane but his membership was terminated in 2018 after he was outspoken about his concerns over commercial influence in the organisation. On hearing of the new policy, he tweeted: ‘Semmelweis never told doctors to wash one hand only. Wash both.’ He went on to say: ‘Cochrane’s ‘strengthened’ commercial sponsorship policy is like eating the cake and still having it. It is like going from declaring to your spouse that you are unfaithful half of the days in a month to ‘improving’ by declaring that from now on you will only be unfaithful one third of the days.’”

A year later, I became so provoked that I fired two more tweets about doctor charlatans: “Now that I have declared to my wife that I am unfaithful sometimes, I might as well screw any woman who passes by ... My financial conflicts of interest related to the drug industry do not influence my judgment, as I work for so many companies.”

So, prostitution is okay, if you have many customers, right?

## Editorial misconduct and protecting psychiatry and the drug industry

Patients with an acute psychosis may want to be sedated, and a Cochrane review showed that this can be obtained quicker with a benzodiazepine than with a psychosis pill.[1536] However, the authors of another Cochrane review of psychosis wrote in the abstract that, "compared with haloperidol, there was no observed effect for benzodiazepines for sedation.”[1537] This was a highly misleading denigration of benzodiazepines as they had the same effect as haloperidol, a neuroleptic. I contacted Cochrane about this, but it took five years and a lot of persistence on my part before they changed the text.[1538]

I first wrote to the primary author, Hadar Zaman, in June 2018, and asked him to correct the abstract. He didn’t do that but forwarded my comments to the Cochrane Schizophrenia Group and said they would come back with guidance.

They didn’t. I wrote to Zaman again, copying the Managing Editor of the group, Claire Irving, and also sent my criticism via the Comments function in the *Cochrane Library*. Yet again, I was ignored. Irving replied that the group would respond “as soon as possible” but three years later, I had still not heard from them although Cochrane is obliged to publish relevant comments alongside the review without delay.

I submitted my comment to the group again, repeating that I wondered why the authors had not quoted a similar Cochrane review that showed that the desired sedation occurred significantly more often on benzodiazepines than on neuroleptics.[1539] Over a year passed, with no reply. I therefore sent a complaint to Cochrane’s Editor-in-Chief, Karla Soares-Weiser. She replied that she would let me know when my comment had been published.

She didn't. Three months later, I checked the review and saw that my comment was published. But there was no reply to it in the review, and nothing had been changed in the seriously misleading abstract. This was editorial misconduct.

In March 2023, I contacted Karla again, and in May, John Hilton, with the impressive title, Head of Content Publication and Policies, Cochrane Central Executive, wrote to me that the review had been amended - the abstract now said that there was no difference between haloperidol and benzodiazepines - and a response was published, not by the authors, even though it was their obligation. There was a response from the "Editorial base," which was problematic. The editors downgraded their error by saying, "sometimes the phrase can be misinterpreted." No, the sentence "there was no observed effect for benzodiazepines for sedation" will *always* mean that benzodiazepines don't work!

The editors didn't find it relevant to comment on the Cochrane review that found faster sedation with benzodiazepines than with neuroleptics arguing that it only assessed the acute effect. This was also plain nonsense. The review I criticised was about psychosis-induced aggression or agitation, which are acute conditions.

My comment is now part of the Cochrane review,[1540] but, unfortunately, the PubMed abstract is still the old, misleading one.

Cochrane mental health groups are so keen to protect the false ideas they have about psychiatric drugs that they are willing to sacrifice scientific honesty and the patients to protect the psychiatric guild and the drug industry. Cochrane's motto is "Trusted evidence," but, as I have explained, Cochrane reviews of psychiatric drugs should be distrusted.[1541]

The only time I ever heard from the Cochrane Schizophrenia Group was five years earlier, when they replied they would respond "as soon as possible." This was the third time I experienced it took Cochrane five years to act. The two other cases were about the harms of mammography screening (see page 86) and empty graphs. It took me numerous emails and requests at meetings and to committees before I succeeded to get empty graphs out of Cochrane reviews, although it is highly unprofessional to publish page after page with empty graphs. Some people had many outcomes in their protocol and constructed graphs for them before they knew if there were any data. The curious reply I got when I complained was that it was good to display these graphs, as they indicated that there was a lack of data, and that they were nice to have in case any future trials contained these data. Rasmus Moustgaard, the chief Cochrane programmer, who worked for me in Copenhagen, told me that a simple command would prevent empty graphs from being seen and printed. The Cochrane bureaucracy was really frightening.

Cochrane also committed editorial misconduct and protected the psychiatric guild and the drug industry in relation to depression pills. The misconduct was so serious that it was a sort of requiem for Cochrane.

Over 100 million people worldwide take depression pills. About 50 million will experience withdrawal reactions when they try to stop; in 25 million, the symptoms are severe; and a survey of 580 people reported that in 16% of the patients, the withdrawal symptoms lasted more than three years.[1542] It is therefore very important to know how we may best help patients come off their drugs. But when we wanted to find out, Cochrane sent us on a mission that was impossible to accomplish.[1543]

At a meeting in Oxford in 2016, psychiatrist Rachel Churchill, editor of the Cochrane depression group, showed great interest in my proposal to do a Cochrane review on withdrawal. I employed psychologist Anders Sørensen, but when we submitted our protocol, it

was not welcomed. After an arduous process that took two years, they rejected our protocol. Cochrane raised their demands along the way to absurd levels with many irrelevant requirements including that we should add marketing messages about the wonders - according to Cochrane dogma - that depression pills can accomplish.

Even though our protocol was very simple (4 pages and 15 references), it took nine months before we got any feedback. We promptly replied and submitted a revised protocol. Seven weeks later, we were told that further improvement was needed.

We submitted a third version and were told that we would hear from the group "shortly." Three months later, we asked for an update and were told we would hear from the group "by the end of the week." After another month, we inquired again. The managing editor said she had prioritised our project and had done everything she could to speed up the process. We therefore suspected that her boss had obstructed the process to wear us out so that we would withdraw the review ourselves while the group would not be seen as being unhelpful.

When over 18 months had passed, we contacted Churchill again. Seven weeks later, she replied they had received peer reviewer feedback except one, due to be submitted later, and she attached a 30-page document with 86 points. Four editors and three peer reviewers had produced 12,044 words of comments, seven times more words than our protocol. Anders wrote to me that our review was quite simple and that we just wanted to help people who wished to come off their drugs but weren't allowed to do so: "What kind of world is this?"

Churchill sent the 8th review five weeks later, but her invitation from the month before to address the feedback had now metamorphosed into an outright rejection.

The 8th review was an excuse to get rid of us. It is one of the worst reviews I have ever seen. It was 1830 words and, in contrast to the other reviews, it was anonymous. We asked for the reviewer's identity, but this was secret.

The reviewer protected psychiatrists' guild interests and the drug industry by denying a long array of scientific facts and using strawman arguments. Although we had not said anything to this effect, the reviewer accused us of having implicated very clearly that antidepressants are "bad medications" to be avoided, "especially as there is no mention whatsoever of the beneficial effects … I find this argument to be unscientific, and unacceptable in the context of the current evidence base." We were accused of "painting a picture" about avoiding using antidepressants, which did not represent the scientific consensus, and we were told to "Start with a statement as to why antidepressants are considered by the scientific community to be beneficial … in treating a broad range of highly disabling and debilitating mental health problems." We responded that our review would not be a consensus report or an advertisement for the drugs and that it was not relevant to discuss their effect in a review about helping people come off drugs safely they didn't want to take.

Curiously, when Anders submitted his PhD thesis to the university, he was censored again. He was asked to remove the most important paper, our systematic review, even though there was no valid reason to exclude it. One of the arguments was that these drugs also do something good, and that he must therefore describe what they are mainly used for.

The reviewer also asked us to explain the concept of ongoing prophylactic antidepressant treatment, "a well-accepted clinical strategy," but this was outside the scope of our review, and the trials comparing maintenance therapy with withdrawal are deeply flawed because harms are introduced in the placebo group (see page 178).

The reviewer opined that we dismissed many decades of evidence relating to neurochemical changes observed in depression and wanted us to document that neurochemical theories of depression were incorrect. We responded that our review was not the place for

such discussions and that the hypothesis of a lack of serotonin being the cause of depression had been discredited (see page 124). As the reviewer believed in the chemical imbalance nonsense and even mentioned thyroid diseases and insulin, we explained that antidepressants cannot be compared with drugs used to treat such diseases. People with myxoedema and diabetes lack thyroid hormones and insulin, respectively, whereas people with depression do not lack serotonin.

The reviewer accused us of having suggested with no evidence that doctors perpetuate untruths to justify drug prescription. There is plenty of evidence and the patients did not invent the myth about a chemical imbalance; the psychiatrists did. However, editor Sarah Hetrick asked us to write: "People on antidepressants may believe that this is necessary because they have a belief that the difficulties they are experiencing are due to a chemical imbalance in the brain." This is misleading. The patients didn't have such a belief before the psychiatrists gave it to them!

The reviewer claimed we conflated disease reappearance with withdrawal symptoms. In contrast to the reviewer, we didn't. The reviewer argued that it is not an acceptable definition of dependence that an effective drug is not effective when stopped but we had not postulated anything so foolish, neither in the protocol, nor elsewhere.

The reviewer argued that most people who had taken antidepressants for extended periods could stop safely, even though we had documented and referenced in our protocol that this idea was false.

The reviewer wanted us to remove this sentence: "the patients' condition is best described as drug dependence" arguing, with reference to the DSM-IV drug dependence criteria, that it is an unreasonable misappropriation of a term. We responded that craving larger and larger doses as a criterion for dependence is absurd, as it means that no one who smokes 20 cigarettes every day is dependent on smoking cigarettes.

An editor asked us to describe how the drugs work (they don't work) and what the differences are between them, and a reviewer asked us to explain when it was appropriate and inappropriate to use them, but we were not writing a textbook of clinical pharmacology.

Although it is true that "some people get terrible withdrawal symptoms," a reviewer wanted us to trivialise this harm by writing that, "some people get withdrawal symptoms that can negatively impact the quality of life of the patient." This must be at the top end of British understatements. We changed "terrible" to "severe."

Another absurd demand was when the Cochrane editors asked us to mention that "some antidepressants may be more effective than others," with reference to the totally untrustworthy 2018 network meta-analysis in *Lancet* by Cipriani and colleagues[1544] (see page 133).

In reality, very few changes to the protocol were needed. We therefore appealed Churchill´s rejection, responded to the comments from all the reviewers and submitted a fourth version of our protocol. We ended our letter to Churchill by pointing out that the Cochrane Collaboration is about collaborating and being helpful to each other.

But she ignored us. After two and a half months of waiting for a reply, we complained to Cochrane's Editor-in-Chief, Karla Soares-Weiser, about the inappropriate rejection of our protocol. She replied we should appeal to Chris Eccleston, Senior Editor for the Mental Health and Neuroscience Network. Before we did this, we appealed again to Churchill who responded with a lie. She said that our protocol was finally rejected before we received the 8th peer review and that she only forwarded this review to be helpful.

Our long-held suspicion that Cochrane wasn't interested in helping patients come off their psychiatric drugs now rose to certainty.

Our appeal to Churchill was not assessed by her but by Rebecca Fortescue, the editor of the Cochrane Airways group, who upheld the rejection decision. It was a mess. Even though Fortescue had provided a list of 11 documents she received from the review group, it was not possible to see what they were about. And it was clear that she had not received our reply to the 8th peer reviewer or our revised protocol, as we had already complied with many of the issues she raised in her 2.5-page assessment.

According to Fortescue, there was little doubt about our stance on "the relative harms and benefits of psychiatric drugs, which does not fully reflect the current international consensus and could cause alarm among review users who rely on Cochrane's impartiality." We politely noted that, "We are a bit surprised about this comment." Cochrane is not about consensus but about getting the science right. Assessing the harms and benefits of drugs was outside the scope of our review, and we did not offer any "stance." Other of Fortescue's criticisms were also unwarranted.

It seemed to me that our adversaries in Cochrane were unable to think clearly. Fortescue, the editors and the peer reviewers did not understand that "Types of participants" were people taking pills who wanted to come off them, even though we had pointed this out repeatedly. As the withdrawal symptoms are similar for any type of patient, disease or depression drug, it was absurd that Fortescue wanted to have a clearer description of the population, intervention and comparators, e.g. if we would include trials in migraine prophylaxis, chronic pain or urinary incontinence. One of the editors asked for details about which ages, sexes, settings, diagnoses of depression, and types of antidepressants we would include, as if we were planning to do a randomised trial.

They were fools. We included *everything*, which was clear from our protocol, and our broad approach was the right one, which I explained in 2000 in a *BMJ* article.[1545]

We appealed to Eccleston who summarily rejected our appeal without a single relevant comment.

Next, we appealed to Karla whose reply can be translated as: Guilty! In a few sentences, she claimed to have looked carefully at everything: "The comments obtained from the open peer review process consistently indicated a lack of clarity regarding the review methods proposed and, despite more than one opportunity to address this, the protocol did not show sufficient evidence that this progressed ... having considered all the information, my final decision is to uphold the rejection of the protocol."

It was not an "open peer review process." The 8th reviewer was anonymous, and we could not even check if our hangman had unacceptable conflicts of interest.

This tragedy showed that Cochrane, once a highly trusted and idealistic organisation, had spiralled towards the ethical and scientific bottom. It is a self-serving juggernaut whose leaders do not care about the ever-increasing workload they create for the unpaid volunteers who produce all the wealth Cochrane has.[1546]

In March 2023, I sent a complaint to Karla about editorial misconduct in an open letter.[1547] I also complained to Cochrane's CEO, Catherine Spencer, as Karla, a psychiatrist, was conflicted in relation to my complaint. I asked some simple questions they refused to answer, and they did not submit my complaint to a due process. I have described the bizarre interactions I had with the Cochrane leadership in this matter elsewhere.[1548]

They beat about the bush, just like the drug industry does when they have a problem, and it turned out that Cochrane has no mechanism for handling allegations of editorial misconduct in an impartial manner, something all reputable journals have. My translation of the message I got from Cochrane's CEO was: "We don't give a damn. We are beyond reproach."

I complained to Wiley, the owner of the *Cochrane Library*. They replied that, "we do not believe that the responsible handling Editors were acting in bad faith. Further, our investigation reassured us that the Editor followed editorial policy consistent with Cochrane's policy." Bullshit comes in many forms.

I found out that, while we were being blocked from conducting our review, another group had submitted a similar protocol and in 2021, Cochrane published this review.[1549] It was restricted to adults with depression or anxiety, which is irrational. Moreover, it did not include trials comparing different withdrawal strategies, which we did, whereas it included many flawed studies comparing abrupt discontinuation (cold turkey) with continuation, which are of no interest.

The Cochrane review is 209 pages, the length of a full book, 23 times as long as the review we published in a medical journal of 9 pages.[1550] The Background section in the Cochrane review, 4239 words, was longer than most scientific papers and full of irrelevant marketing hype and misleading statements, which I had noted in my complaint to Cochrane's CEO. To "prove" that the drugs worked, the authors cited the totally flawed review by Cipriani et al., which did not find a clinically relevant effect.

The Cochrane review is unbalanced. It gives precise but misleading estimates of the benefit in the form of number needed to treat to benefit one patient (NNT) but does not offer similar estimates for the most serious harms. This goes against the very ethos of Cochrane, which is to focus similarly on the benefits and harms of interventions. The Cochrane review mentions suicidality in many places, but it does not say that depression drugs double the suicide risk, both in children[1551] and adults (see page 138).

The Cochrane review declared that continuation of antidepressant treatment reduces the risk of relapse and recurrence by 50% to 70%. This is horrible misinformation. People who are randomised to a cold turkey develop abstinence symptoms that are misinterpreted as relapse (see page 178).

When we established the Cochrane Collaboration in 1993, we wanted to assist *patients* in their decision making. However, the Background section is about what *doctors* think and the review is highly paternalistic. There is no mention that many patients want to come off the drugs, which should have been the key motivation for the authors to do their review.

There is no mention that the tapering should be hyperbolic, whereas the authors quote a 2009 NICE guideline that recommends a fast, non-hyperbolic tapering, which they don't criticise. When we started Cochrane, we were willing to criticise the authorities. The current leadership wants to please the authorities and the drug industry.

The abstract of the Cochrane review is excessively long, 915 words, and states that "We cannot make any firm conclusions about effects and safety of the approaches studied to date." Really? We made firm and useful conclusions in our review, which we published in a journal whose editors are not morally corrupt and have the patients' interests as their priority.[1552] A median of 50% of the patients succeeded to withdraw their depression pill, and the length of taper was highly predictive for the success rate (P = 0.00001). All the studies confounded withdrawal symptoms with relapse; did not use hyperbolic tapering; withdrew the drug too fast in a linear fashion; and stopped it entirely when receptor occupancy was still high. The true proportion of patients on depression drugs who can stop safely must therefore be considerably higher than 50%.

Maryanne Demasi and I explained what our review means on a website.[1553] When we first published it on a preprint website, we noted an internal problem I had encountered,[1554] and I published a comment on *Mad in America* about it:[1555]

Initially, the two researchers were Peter C Gøtzsche and the PhD student he had employed, psychologist Anders Sørensen. We submitted the review to a journal, which was very interested but asked for a revision. Sørensen promised to revise the manuscript but did nothing.

He did not respond to emails, never picked up the phone when he could see it was Gøtzsche who called and ignored telephone messages. After a year, Gøtzsche lost his patience and updated the literature search, added a new trial, responded to the peer review comments, and sent it all to Sørensen. When Sørensen continued to ignore Gøtzsche, he asked the journal for advice. The editor suggested he drop Sørensen and add a new author, as there was a new trial to consider. Gøtzsche submitted the revision with Maryanne Demasi. Then, the editor of the journal succeeded in making contact with Sørensen, who suggested his own changes, but sent them directly to the editor, without copying Gøtzsche or Demasi.

Gøtzsche added Sørensen's name to the paper again, agreeing to most suggestions and resubmitted it to the journal. Then, again, Sørensen ignored all further emails from the journal, so we were instructed to publish without him, because the rules stipulate than an author must approve the final version.

The Editor-in-Chief asked Gøtzsche to get Sørensen's signature confirming he was OK with not being an author. This was an impossible task, since Sørensen was now not responding to Gøtzsche or to the journal. We sought to ensure that Sørensen was in fact well, and we eventually established that he had been active with other projects.

The Editor-in-Chief got cold feet and asked the journal's ethical team. After this, we were told they could not publish the paper.

The paper is highly important for psychiatric patients and for those who want to help them come off their drugs, which is part of Sørensen's clinical practice.

It is unacceptable that a researcher is allowed to block publication of important research in the general interest. Since the standard is that researchers are free to publish independently if they cannot agree, we have decided to publish the review ourselves.

## Wilson's CV: He forgot to say he was on the Moon

When I got elected to the Governing Board in 2017, I asked to see Wilson's application and CV. They screamed out loud that this was a character to be avoided.

Wilson wrote that when he was at the International Federation of Red Cross and Red Crescent Societies, he "reduced headcount and costs ... When I joined Panos London in 2004 the organisation was on the point of bankruptcy but within four months I had raised over a million pounds to keep it alive ... I designed and implemented a major restructuring which cut staff by nearly 50% but ensured the continued existence of the organisation."

When he was "Operational Manager - Balkans: Geneva June 1996 - March 2000", he "Raised and managed US$30 million per year to support humanitarian operations … benefiting hundreds of thousands of beneficiaries."

Wilson's CV is so extraordinary that my filmmaker Janus Bang said: "He forgot to say he was on the Moon." All alarm bells should have rung, but no one in Cochrane investigated if these impressive results were true. As Wilson is a journalist, he knows how important publicity is. It should therefore have been easy to find mention of some of his Superman achievements in newspapers, but I found absolutely nothing.

Another warning signal was that his 9-page CV said nothing about where the hundreds of millions of dollars came from. One *always* writes in a CV where essential funding came from, and it is extremely rare that a funder asks for anonymity. The origin of vast amounts of money is usually only hidden if they come from organised crime. Wilson once told me that he had a lot of

experience from Russia and had worked there. In his CV, he boasts that he completed a two-year post-graduate degree at the University of Glasgow in just one year, which was about foreign and security policy, and economic and monetary policy, in the Soviet Union. He also learned to speak Russian. People who have tried to investigate his Russian connections did not get far before they were warned that it could endanger their health if they continued asking questions.

How could such a person become the CEO of Cochrane? Well, my access to confidential documents as a trustee enabled me to find out that there was already institutional corruption before Wilson got employed. The criteria for shortlisting applicants for interviews were totally different from what the applicants had been told an ideal candidate would look like.[1556]

The CEO post was hugely important for Cochrane, also considering that the two previous CEOs had not performed well. A panel of eight named people would select people for interviews, but the panel had only a weekend to read the many applications and agree about which candidates to interview.

I found this inappropriate, and the rules were broken. Only three people, Craig, Grimshaw, and the interim CEO, Paul Farenden, selected the people to be interviewed. Kay Dickersin, the US Cochrane Center director, was also on the panel and she told me that she didn't even know who the other applicants were (one of them was me).

I complained about the lack of due process and the violation of the rules and called for the whole procedure to start all over again, noting that what had happened would not have been accepted in my country. I used a sports allegory: If you tell a football player where the goal is and move the goal after the player has aimed and kicked the ball, it would not be acceptable.

I asked for a reply within the text of my letter, point by point, but my most important questions were not answered:

Were all the applications sent to all panel members in advance of the shortlisting meeting?

Will the CV of the CEO, and possibly also the application, be made available once the new CEO has been appointed? I noted that we need to be very cautious that we follow generally accepted procedures and make transparent and democratic decisions so that it cannot be criticised afterwards and doesn't leave unhappy people behind.

Was any formal process decided beforehand outlining what steps would be taken? I asked to receive a copy of this document if it existed.

My questions were not answered. Craig responded that "Your concerns about the process have been noted, but we are moving forward to appoint a CEO in a timely manner for the benefit of the Collaboration." This is how they select presidents in dictatorship states.

I talked to Grimshaw on the phone, and he told me that I would be very impressed if I knew the names and credentials of the 15-20 people that had been shortlisted for interviews among the 50-60 applicants. If that were the case, then why on earth did they select Wilson for the job?

I consulted with various people who urged me to bring these matters to the Steering Group, which I did. But Craig sent another meaningless mumbo jumbo reply, claiming that the process had been fair and equitable: "We would request that you respect the process and the decisions that have been made, which we believe are in the best interests of The Collaboration." Wilson? In the best interests of the Collaboration? Surely, you are joking, Mr Craig! I had battled with Craig earlier when he argued Cochrane should accept industry money. I felt Cochrane leaders behaved like the Soviet and Russian leaders did.

The same month, Kay told me that the governance was broken, and that there were serious conflicts of interest, which included a personal relation between Craig and Burton and that both

co-chairs had employees in the Steering Group. The breaking of the rules meant that the co-chairs could do what they wanted, which raises the suspicion that Wilson was favoured in some way and might have been planted. Did anyone know about him beforehand? Did anyone tell him he should apply for the job? Was it pre-arranged that he should become the new CEO?

Since the co-chairs did not upload Wilson's application and CV for everyone to see, despite my request, I did this in 2022.[1557]

In 2019, I tried to find out what happened when Wilson worked for Panos, which was his last job before he came to Cochrane. That was not easy, but my efforts were rewarded.

Wilson worked as CEO at Panos for eight years, "one of the world's leading communication for development organisations … with more than 200 staff in over 20 offices in Africa, the Caribbean, Europe and Asia, and a combined budget in 2012 of £11.5 million."

Also in Panos, Wilson centralised "managerial accountability" under himself in London, introduced a huge bureaucracy, and produced a Strategic Plan 2010-15, which led to a "profound strategic reassessment and re-positioning of Panos London." Wilson's euphemism meant he wanted to have total power and control over everything, just like in Cochrane. He boasted that he introduced "rigorous, effective and efficient internal organisational processes focused on Panos London's areas of demonstrable expertise and added value."

But Panos stopped existing right after Wilson left and had restructured it. It was strange that, considering all his efforts, the London office closed in 2012. There must have been huge problems for Wilson when he applied for the CEO post in Cochrane.

I found a donation website where Wilson revealed his narcissistic traits.[1558] There had been a run and "I made it - and in a time of 54 minutes, not too bad for a first-time 10 km runner!" He had raised £140 out of a target of £300 for Panos' work in Haiti. A little different to the hundreds of millions of dollars he claimed to have raised earlier for humanitarian operations in the Balkans.

Did Wilson make people working for Panos internationally equally unhappy as those working for Cochrane internationally? I found an obituary for Panos London by James Deane, Director of Panos for ten years before Wilson took over.[1559] It was long, 2948 words, and mentioned many names for their great contributions, but Wilson's name did not appear at all. It is of note that Deane had decentralised the organisation and had given the international units the freedom they needed while Wilson did the opposite.

It seems Wilson destroyed Panos in the same way as he destroyed Cochrane. Deane noted that the agendas needed to be defined and driven from within developing countries and that Panos' purpose was to provide access to trusted information that doesn't tell people what to think but provides the facts they need to make up their own minds about an issue and to have their say. This was the exact opposite of Wilson's ideas for Cochrane where free debate was not allowed, and where all should speak with one voice. But a scientific organisation that does not allow self-criticism will degenerate and ultimately disappear.

Deane wrote that they could not legitimately make decisions by sitting in an office in London and that they created regional Panos Institutes, accountable to their own boards, which was more legitimate and necessary to sustain funding, "especially given the questions I kept on being asked by our loyal Scandinavian donors of why they should support an organisation based in London." This was exactly the kind of organisation and reasoning we had in Cochrane before Wilson came along and destroyed it.

Wilson's self-praise in his CV includes: "great cultural sensitivity … ready to admit mistakes and learn from them … The ability to manage cross-cultural organisations and teams is, I believe,

one of my greatest strengths … I am an outstanding writer and speaker, completely at home in front of a camera, giving speeches or facilitating large or small meetings … I have a personal library of over 4,000 books and journals on international political, economic, social and development issues and continue to update my knowledge and expertise in these areas."

Wilson's grandiose sense of self-worth is a psychopathic trait, and it contrasts starkly with people's views of him. In 2015, an independent assessment of his performance during his first three years in Cochrane was carried out by a committee of 12 people who gave their opinions about his leadership. They were devastating and included:

The CEO of Cochrane cannot operate as a CEO of a business company, and a top-down culture is new. Mark doesn't answer when he doesn't like the suggestion. He can be defensive, talks a lot, does not always seem to want to work within the culture. He does not trust Cochrane contributors. His standard mode is combative, which can waste time and put people off. Might be good to develop his ability to listen. He should work collaboratively with the outstanding people he is surrounded by. Mark does not accept the fact that he reports to the Steering Group; he does not demonstrate an appropriate level of respect for its members and is not receptive to being challenged either by an individual Steering Group member or by the group as a whole. The balance of power between the CEO and the Steering Group must be carefully considered. It is important not to play off members of the Steering Group against each other and 'snow' the group. Trust is a critical element in this organisation, so trust has to be earned and built.

Despite his self-declared capabilities in person management, Wilson lost many of his own staff during his time in office. After there had been a particularly high turnover, Wilson described his poor leadership in positive terms in an email he sent to everyone in Cochrane in early 2018. My reaction to his headline, *New structural changes to Cochrane's Central Executive Team (CET)*,[1560] was that he must be in great trouble.

In 2017, the National Institute of Health Research (NIHR) in the UK published an evaluation of the health and economic impact of Cochrane reviews.[1561] The NIHR spent about £6m a year supporting the UK Cochrane Centre and the 21 Cochrane review groups based in the UK out of 52 worldwide. I knew three of the six assessors, and according to one of them, Jos Kleijnen, former director of the Dutch Cochrane Centre, the NIHR wanted to cut all the funding because it took so long for a review to be published, but the evaluation team persuaded them to continue.

The NIHR was also unhappy with Wilson's leadership. According to another assessor, Paul Garner, editor in the Cochrane Infectious Diseases Group, Wilson single-handedly pulled in people in leadership positions that others with more knowledge about them and the local situation had found unqualified; he had contacted UK funders, but they didn't trust him; he had increased funding where more knowledgeable people had decreased it earlier because of poor performance; and the assessment report was quite critical of the huge staff at the CEO office.

## The emperor embarrasses himself in front of his entourage

When the Governing Board met in Lisboa in March 2018, Wilson and I had a meeting in relation to the complaint from Torrey. Wilson also wanted to discuss Loonen, and a question by Anton Pottegård sent as a tweet. I brought Joerg Meerpohl and Karsten Juhl Jørgensen to the meeting as witnesses and also recorded the meeting secretly, as I knew Wilson could not be trusted.

The minutes were produced by Sarah Watson, Cochrane's Head of Finance & Core Services, but Wilson must have tampered with them, as important bits that were incriminating for him had been left out of what looked like a verbatim report.

I asked Wilson for an amicable solution and to remove the damaging statement about my 2015 *Daily Mail* article on Cochrane's website. To no avail.

After 27 minutes, Wilson said I had broken "the Spokesperson Policy and additional undertakings." But the start of my reply had been deleted: "Wait a minute, Mark, I did not break the Spokesperson Policy." This is significant for what happened soon after when Wilson embarrassed himself totally.

A little earlier, I had said that there cannot be separate rules for me and not everyone else. I added: "In Genève, the board agreed at a meeting where you weren't present that I could use the letterhead and Cochrane affiliation as long as I make it clear if there was anything to be in doubt about that these are my personal views."

The minutes were seriously misleading: "In Geneva, the board agreed that I could use the letterhead and Cochrane affiliation as long as I make it clear these are my personal views."

The omissions, "where you weren't present" and "if there was anything to be in doubt about" are essential. As there never was any doubt, Wilson could no longer claim that I broke his Spokesperson Policy when I used my centre's letterhead. But he ensured not only that the minutes from Genève became untruthful (see page 324) but also that the current minutes became untruthful.

Two days after this meeting, Burton took Joerg and me aside, one by one (not together, which was his way of exerting power), and tried to convince us that we should not bring up the Spokesperson Policy during the board only time in the afternoon (where Wilson was not present and therefore could not control the board). Burton told me there was no reason to discuss it because I had broken the policy, to which I replied that this wasn't correct and that he didn't know the details.

But I considered following Burton's advice and therefore had a brief meeting with Wilson during the coffee break, with Joerg as my witness. I asked him again for an amicable solution where he didn't deliberately undermine me to my enemies, as it was harmful for my Cochrane work. I asked him again to remove the damaging statement about my *Daily Mail* article. He didn't respond but just stared at me, in his "my eyes could kill you" way.

I tried again to be friendly with him and said that he and I needed to work together to achieve good things for Cochrane, but he continued staring. I then asked why he always wanted to punish me instead of protecting me. He replied it wasn't about that, but that I had broken the Spokesperson Policy, which he would need to point out to outsiders. He claimed I had admitted two days earlier that I had broken the policy. I said this was not the case. I had only said that my deputy and I interpreted the policy differently to him.

Wilson totally lost his temper. He shouted, called me a liar, and said that I couldn't be trusted because I changed my views all the time. He pointed his finger at me and hammered his hand very hard on the table, took Joerg firmly by the shoulder and said that, as he was there, he could confirm I had admitted I had broken the policy.

Joerg said he could not remember anything to that effect, and when I rang Karsten a little later, he confirmed that I had not said I had broken the policy. When I listened to my secret recording later, it confirmed this fact.

Wilson's outburst was witnessed by two other board members, Janet Clarkson and David Hammerstein, and Clarkson considered intervening, as she was very disturbed by Wilson's physical aggression.

Joerg was so shocked about Wilson's bullying behaviour - management by fear where Wilson tried to threaten him into agreeing to something that wasn't true - that he brought it up during the board only time. When Gerald said there had been several other instances of Wilson bullying people, he was quickly stopped by Burton.

Wilson never apologised that he called me a liar; to him, I was already a non-existing person. Joerg humbly approached the tyrant to get on good terms with him. I would not have done that. In the early 1930s, naïve politicians in the German Reichstag including the Chancellor, thought they could control Hitler by being kind to him.

A week later, Wilson lied again. He sent an email to the co-chairs where he claimed that I had said that the board had decided in Genève that the special requirements for me about the use of my letterhead were no longer in place. I never said this. I drew a logical conclusion. Since I could use my letterhead freely, there could not be any additional requirements when I used the letterhead. Joerg supported me: "There are minutes from the 'board only' time to confirm."

I did not realise that when a citizen has pointed out a tyrant's wrongdoing and logically and calmly has caused him to lose his temper and embarrass himself totally in front of his Court, the citizen must disappear. This explains what came next.

The way Burton described these events in the 330 pages he sent to Cochrane's law firm on 2 July 2018 (see below) was deeply dishonest, and it is an aggravating factor that Burton knew what had happened. Burton wrote in the report that Joerg had witnessed "the strong words and disagreement," but did not explain that the "strong words" came from Wilson or that he was physically aggressive. Burton's misrepresentation of the facts was grave, as his report was the basis on which the law firm hired by Cochrane was meant to form an objective and fair assessment.

Burton wrote that he immediately tried to stop all discussions during the board only time about "these matters" and that this was supported by trustees "with significant and relevant governance experience," as if this reference to authority – alien to Cochrane thinking – would somehow justify Burton's inappropriate intervention.

Burton lied. Virtually all board members were interested in discussing Wilson's bullying behaviour and they were shocked that Cochrane's CEO acted like this towards two elected board members. We therefore spent quite some time discussing it.

Burton wrote that "it was difficult to stop Peter Gøtzsche speaking," which was also mendacious. I had questioned his argument that we should not discuss Wilson's bullying behaviour because - it was claimed - that it might jeopardize the board's judgment about spokesperson issues. I was not the only board member with the view that these were totally separate issues. Furthermore, Burton was inconsistent. In his plan for my demise, he allowed Wilson to connect the two issues. Some are more equal than others in Cochrane.

Burton also lied when he mentioned "a serious allegation concerning the behaviour of Mark Wilson as CEO." Something four board members witnessed when Wilson totally lost his temper and became physically aggressive is not an allegation, it is a fact.

## Wilson escalates the conflict in the extreme

Only a month later, Wednesday afternoon on 11 April 2018, Wilson escalated our conflict in the extreme in a long email, 47 pages when transferred to Word (including the server

details), with nine full-text attachments. He claimed I had broken the Spokesperson Policy in relation to my letter to the US funder, which was nonsense (see pages 319 and 361).

After he had had six weeks to think about it, Wilson requested that I respond to his allegation within two days because he wanted to reply to Torrey before the weekend.

The same day, I sent a draft of my initial reply to Wilson to three board members, Joerg, Gerald and David, and asked for their comments. Joerg fully supported it. He was surprised that we had not received the minutes from Lisboa on this issue and found that giving me a deadline of two days and threatening to close my centre were inappropriate. David agreed that I should notify the board of this. He was shocked by Wilson's response to a criticism written by someone probably motivated by the drug industry and felt this kind of response would encourage Cochrane members to inhibit themselves and impose self-censorship.

I did as advised. I wrote to the board and Wilson and asked Wilson to respect the decisions the board had made. I noted that I could not meet Wilson's extremely short deadline because Danish TV would be filming us one full day (a bit ironically, considering the complaint, because they were very impressed with our work related to helping psychiatric patients), and because I would lecture in Stockholm the next day.

In his long email, Wilson's misinformation about what was decided in Genève just continued. And as my deputy only had the centre affiliation, should we then give two different addresses when we were interviewed together? When I got my professorship in 2010, it was announced in *Cochrane News* as a "Cochrane Professor … We see it as an academic recognition at the highest level of the important work of The Cochrane Collaboration".[1562] This showed it was impossible to separate my professorship from my job at the centre. When I tried to find the message again in 2019, it was gone. Wilson likely took it down. Like Stalin, he tried to erase history after having eliminated his enemies.

Wilson's threat to deregister my centre, if I failed to follow his orders, which could have rendered about 50 people jobless, showed his appallingly poor leadership. Tyrants operate this way. If they cannot find the resistance fighter, they will punish the whole family.

I informed the Governing Board immediately because the board had decided three weeks earlier that Wilson's allegations that I had broken the Spokesperson Policy and my reply would need to be considered by the board before he took any action. I reminded the board of its decision and asked Wilson to respect it.

After the weekend, I replied to Wilson and asked the board for its views, expecting that the dispute would be settled. In a well-functioning charity, this would have happened, but this was Cochrane. Wilson became enraged that I had challenged his omnipotence by involving the board. According to the binder Burton sent to Cochrane's law firm three months later, Wilson said: "In my view this is an outrageous email. I addressed the email only to Peter as his line manager, so his response (without copying the Board) is unacceptable. It is also full of factual inaccuracies."

Wilson lied again. There was nothing outrageous in my email; there were no factual inaccuracies; and he didn't give a single example. I also wondered what he meant by "without copying the Board," as I wrote to the board. Wilson complained that I involved the board, but board members are entitled to write to each other, which Cochrane's own lawyer confirmed at the completion of his investigation.

These events are crucial for understanding Cochrane's demise.

David wrote to the board, praising my reform work aimed at reducing the harms of psychiatry and warning that the reputation of Cochrane could be seriously harmed. But Wilson and Burton didn't bother the least about the consequences for Cochrane. Burton tried to

make it an issue only the co-chairs should be involved with, but as this would mean a high risk of further manipulations by Wilson, we found that the whole board should be involved. Three more board members shared our views. Thus, at this time, a majority, 7 of the 13 board members, were opposed to what was happening.

We did not respond to Burton's email.

I sent Wilson's two draft replies, one to Torrey and one to Pottegård (see page 361), with my comments inserted and other relevant documentation, to the board and Wilson, and asked for the board's views. I did not need any permission from the co-chairs to do this, but the replies from three board members, Rae Lamb, Tracey Howe, and Catherine Marshall, illustrated the extent of Cochrane's moral collapse. They asked me not to send any more emails to them related to my role as a centre director. But that was not the issue! The issue was that Wilson lied about what we had agreed and he violated the board's decisions. It was outrageous that these three women supported Wilson's bullying of me, his control of the board, and a totally unfair and undemocratic process against an elected board member.

Rae Lamb

Tracey Howe

Catherine Marshall

I was in a catch-22 situation. Could I write to the board or could I not? I would be punished whatever I did. One of the board members wanted to formalise the process, which Burton happily did. He loved formalising things that could have been dealt with easily and quickly and turned them into elaborate "processes," which he and Wilson could control.

David wrote to me, Joerg and Gerald that I should answer Lamb that I addressed the board precisely because I was dissatisfied with the process being carried out by Wilson. He called it a Kafkaesque trial where the accused only communicated with the accuser, and no one knew what was going on. I replied that Wilson had also violated the agreement he had entered with me - the Memorandum of Understanding.

Tom Jefferson, whom I had employed half-time, disagreed profoundly with Wilson that my letter to the US funder was outside the scope of Cochrane. In that case, Tom should not have asked Roche for the full Tamiflu trial data, which showed that what Roche had published and claimed was fraudulent (see page 293). The Cochrane leaders should have praised Tom for his stubborn persistence in getting the truth out, but they were uncomfortable because the truth had tarnished the drug industry's public image.

The rules were totally broken. The Torrey issue was not even an issue, but I was now up for extermination. Nine days after Wilson's abominable email, the show trial against me started, no doubt initiated by himself. He acted as an *agent provocateur* by sending an email to me he knew I could not accept and must have instructed Burton beforehand how he

should react to create a catch-22 situation for me. Hitler invaded Poland with the excuse that Polish soldiers had attacked Germans, but he had himself arranged this fake attack.

On 18 April, I reminded Wilson that, in case we could not agree, the Collaboration Agreement between him and me specified that it was my right to take the matter to the Governing Board, which would then make a decision. I also noted that he could therefore not send replies to Torrey and Pottegård without my explicit agreement.

Wilson must immediately have contacted Burton when he saw my email. Less than two hours after I had sent my email to Wilson only, Burton wrote to the board that I should not send any more emails to the board, although I was entitled to do this.

Tom wrote to me that he would be happy to give his views on the record to Mark Wilson or anyone else. In his draft, he noted:

"For some time I have been uncomfortable with what I see as a witch-hunt against Peter Gøtzsche ... Perhaps his greatest achievement, the opening of the previously secret regulatory world, has gone unremarked … some of his previous forays, showing for example that the benefits of breast screening had been inflated are now part of mainstream thinking. Several Kuhnian paradigm shifts, all because of one man. At present Peter is doing what he has always done: challenging orthodoxy. This time in psychopharmaceuticals and in the psychiatric paradigm. The Spokesperson Policy … must not be used to try to silence anyone, especially not on the basis of their work ... I am great admirer of the courage of Peter and all those tree shakers like him who have made Cochrane what it is now. I also need to disclose that Peter's Centre is also funding me to do some more tree-shaking. Those who use corporate methods to silence scientists attract my attention. They make me wonder what their real motives are."

On 20 April, Wilson wrote to me and the two co-chairs that he and I could not agree and that he would let the Governing Board consider the matter. He continued lying about what was decided in Genève and claimed that I could not veto his communications to people who had complained about me, in direct contradiction of the Collaboration Agreement he had himself entered with me.

It was carefully staged by Wilson. Less than an hour later, Burton wrote to Wilson, Farquhar and me that the co-chairs would hire a lawyer to look at the issues and they had written a plan to resolve the situation, which he attached. Wilson had provided input to the plan but I was not asked of course. So much for Cochrane's sense of justice. The plan was nominally about resolving the conflicts between Wilson and me, but in reality its aim was to kick me out of Cochrane.

Instead of letting the board resolve a trivial dispute, which the co-chairs were obliged to do according to our rules, they now made it a big issue. I felt that something really bad was about to happen to me. The only reason there were disagreements was that Wilson lied about everything and constantly accused me of wrongdoing, which was also false.

Wilson replied that he was happy with the plan. Of course he was. It was his own plan. Leaders with psychopathic traits always win over honest people because they violate the rules, which their victims don't.

Wilson thought he could destroy me, with no harm done, but he ended up destroying Cochrane. Once, when I talked with Iain Chalmers about Wilson's incessant witch-hunt after me, before all this happened, Iain replied: "He doesn't know whom he is up against."

I responded to the co-chairs that I disagreed with the plan and explained that it was my right, according to the Collaboration Agreement, to require that the whole board became involved. I was naïve. I still thought that rules mattered but now it was full Kafka.

On 23 April, David wrote to Joerg, Gerald and me that Burton and Wilson were trying to avoid a broader discussion of these issues in the board because they saw that they did not have a clear majority. He also noted that they wanted to avoid having a complaints committee of the board. The plot would have failed if there was an impartial committee.

On 26 April, I sent my full reply to the co-chairs' proposed plan and asked them not to send it to Wilson as I had needed to quote some statements made during the governing board only time.[1563] However, I am convinced that Burton showed my reply to Wilson.

I noted that it's a huge problem for due process that the same person, the CEO, writes the policy; investigates possible cases of violation of the policy without independent oversight; and punishes people for alleged violations. No civilised society allows such an enormous concentration of power in one person. Wilson not only handled all three; he also didn't find it necessary to involve the person complained about before he came up with his verdict. He surely learned something during his years in Russia.

I also wrote that it was astounding and highly one-sided that Wilson spoke about me behaving incorrectly while nothing was said about his own embarrassing behaviour in Lisboa even though the whole board was fully aware of it.

I explained it would be easy for the board to make a decision on the two cases, but I didn't hear anything for the next six weeks.

The plan quoted Wilson for saying that I had behaved incorrectly by involving the board in matters that should be dealt with by himself. This was scary. The victim being alone with his ruler, judge and executioner, all in one person, with no witnesses. Wilson in a nutshell.

## Falsifying evidence in preparation for the show trial

At a teleconference on 13 June, the co-chairs succeeded to convince a majority of the board that a legal review should be undertaken although, as David explained, the dispute was not a legal issue.

I was not allowed to attend for this agenda item. Some of the board members told me that Wilson had threatened the board and had talked about a huge financial compensation because he had been "harassed" by me. He gave them an ultimatum that it was a choice between him and me. How is it possible that one part in a dispute is allowed to be present and make threats while the other part is not allowed to appear?

Two months later, a week before the board meeting in Edinburgh, my IT staff had a conference call with Wilson where he said action would be taken in Edinburgh because I had criticised the Cochrane HPV vaccine review. This was not correct. My research group's criticism was published only 17 days before the show trial,[1564] which was so late in the process that it had no importance for my demise, which Wilson had already plotted with Burton.

Wilson told my staff it was serious and unprecedented that we had published our criticism in a competing journal. This was also false. It had happened many times before, and we did it the year before when we criticised a Cochrane ADHD review, which was subsequently withdrawn.[1565] That Wilson knew beforehand that action would be taken confirms that he had staged my expulsion and controlled the board.

Gerrard Tyrrell from the Harbottle & Lewis law firm wrote to Cochrane that they had completed their review of Burton's binder. Tyrell said there were serious legal concerns for

the trustees. This is how a law firm makes itself indispensable. There were no legal concerns, previous matters were settled, and the current issues were trivial. Tyrell "strongly" advised that Cochrane escalate the problem and pay the firm to conduct an independent review, with advice from Counsel, of the various complaints going back 15 years.

The oldest complaint in Burton's binder was from 2003, and the only reason there were not even older issues was that he could not find any evidence that old. However, Counsel, Thomas Grant, found that even going just three years back would not be fair towards me.

Burton denied me access to the part of the minutes about this issue, but I argued it was my right, and after he had consulted with the law firm, I got them. I thought. I found out that Burton had tampered with the minutes. The identity of the voters had been deleted, in contrast to the minutes the other board members received. The law firm confirmed that the identities of the voters were anonymised following "a request that was made." Those who voted against involving a law firm were those four people who resigned from the board after I had been expelled.

This was Kafka. "A request that was made." Undoubtedly by Wilson. It is a potentially criminal offence to tamper with meeting minutes - falsifying documents - and to mislead a trustee who suspects that this occurred. Burton also changed other documents.[1566]

For the historical record, I have uploaded all the documents in my case on my website, including Burton's binder (330 pages) to Counsel and my 66-page reply to this, which I submitted on 30 August.[1567] I documented mismanagement of Cochrane, which included a Spokesperson Policy that was so ambiguous that it could not be used to discipline Cochrane contributors or to tell them that they have violated it. Counsel agreed that the policy was too ambiguous to be accurately interpreted.[1568]

In my report to Counsel,[1569] I detailed why none of the allegations raised against me had any merit[1570] and documented serious acts of tampering with minutes and other evidence by the CEO, his staff, and the co-chairs. I highlighted - based on an Internet article I can no longer find – that knowingly producing and passing off minutes as accurate and true, when you know them to be demonstrably false, is not simply a matter of maladministration, but is potentially a criminally fraudulent act.

Counsel knew that Cochrane had the intention to expel me and went to great pains to provide a fig leaf to his client, but he completely distanced himself from what they planned to do.[1571] He wanted no part of any of that, and even though he was paid for by Cochrane, he agreed with me that there was no basis for disciplining me.

Counsel came up empty-handed and exonerated me. But the two co-chairs, Burton and Marguerite Koster from Kaiser Permanente, were unscrupulous and conjured up a spurious excuse to expel me. The best they could come up with was to accuse me of "bad behaviour," which they never defined, not even when questioned in public. Without justification, my fate was sealed, and I was booted out of Cochrane.

Being a trustee, I was such a threat to Wilson's omnipotence that he demanded my head on a platter. What led up to this was my criticism of psychiatric drugs. As Bob Whitaker said, it might be tolerated if you nibble at the edges of a medical discipline with criticism, but not if you document that the entire specialty does more harm than good.

Burton's binder illustrates how ridiculous it all was.[1572] In 2003, Steering Group co-chair Jim Neilson criticised that I had listed the Nordic Cochrane Centre as my address in three papers in the *BMJ* and *Lancet*. I told Neilson that, at the centre directors' meeting in Melbourne in 2003, we had agreed that people who are full-time employees at a Cochrane

centre should use this address, since readers might think that the authors try to hide something if they were not honest about their affiliation.

In one of these papers, 11 methodologists reported on the quality of 53 new Cochrane reviews.[1573] We identified major problems in 15 reviews, and the evidence did not fully support the conclusions in 9 reviews, which in all cases were too positive for the experimental intervention.

We informed our Cochrane colleagues well ahead of publication, which was to our own disadvantage, as the Steering Group put pressure on us not to publish the results.

I was summoned to a Steering Group meeting to explain why we wanted to publish. I said that, since we belonged to an organisation that constantly assesses and critiques others' research and points out when inconvenient results are being suppressed, it would be wrong to suppress our own results, which would also be an act of censorship. I noted it would show Cochrane's strength that we were willing to criticise ourselves and that it was important for patients, doctors and others to know that conclusions of Cochrane reviews should be viewed with caution, and that they needed to read more than just the conclusion.

Neilson noted that many in the Collaboration felt our article was misleading because it was out of date (which was not correct), embarrassing, and potentially damaging; further, one entity almost lost external financial support.

However, in science, we hold people accountable for what they publish. Our paper led to other quality improvement initiatives, and *BMJ's* editor gave the co-chairs the opportunity to publish an editorial where they outlined what we did, which also benefited Cochrane.[1574]

I wrote to Neilson that the single most important factor that enabled me in 2001 - after years of struggle - to ensure permanent funding for my centre, for Cochrane's software development, and for the three review groups based in Denmark, was our research.

After our paper, many Cochrane contributors published about shortcomings in Cochrane reviews without being reprimanded. As I have noted earlier, I often came in trouble only because I was first.

Neilson also mentioned that a systematic review of immunoglobulins for sepsis we were about to publish had enraged Cochrane editor Paul Garner from the Infectious Diseases group and that we might have written it in collaboration with the authors of an already published Cochrane review.[1575]

I responded that if we had collaborated with the Cochrane authors, it would not have been an independent replication. Moreover, we had informed Garner two years earlier that we were working on it and Mike Clarke, co-chair of the Steering Group, had written to Garner and Neilson that it would be part of the first author's PhD and therefore needed to be a new piece of work.

We provided an immense service to the whole world, which is more important than avoiding temporarily upsetting a Cochrane editor. But, as Kay Dickersin remarked, Cochrane had become a kind of social club where it was more important not to upset anyone than to get the science right. Cochrane was called a "family" like in mafia circles.

The Cochrane review had concluded that immunoglobulins are effective, and the authors received an award at a Cochrane Colloquium. I sat next to Douglas Altman when this was announced, and we looked at each other in disbelief because the authors had not separated trials with a low risk of bias from those with a high risk, even though this was standard for Cochrane reviews.

Around 2000, intravenous polyclonal immunoglobulin was the second-largest drug expenditure at my hospital even though we considered it highly doubtful if it saved lives in

patients with sepsis. Being a member of the hospital's drug committee, I offered to do an independent review, with my PhD student, Julie Pildal.

We used a more sensitive search strategy and retrieved more information from the trialists than the Cochrane authors had done. We found that high-quality trials (255 deaths) had no effect on mortality, whereas other trials (292 deaths) showed an effect.[1576] We concluded that immunoglobulin should not be used. Later, research carried out at my hospital and elsewhere confirmed our findings, and the most recent version of the Cochrane review from 2013 also confirmed our results.

Interestingly, when I ran for a post on the Governing Board in December 2016, Neilson and Garner were very positive towards what I stood for (see page 322).

In his binder to Counsel,[1577] Burton lied blatantly about Wilson's special provisions for me. He said there was a lack of consensus as to what was agreed at the board only meeting in Genève in April 2017 (see page 324), and he claimed that neither he, nor the other co-chair, Lisa Bero, were aware that the provisions no longer applied. Bero had pushed hard for making the board accept the provisions but failed. The day before, she had taken me aside and told me that the board would very likely forbid me to use my own letterhead. She also took my deputy aside and told him the same thing. When I spoke with Joerg about it, he clearly remembered that the board did not accept that any special provisions were in force for me. But when Wilson did not obtain what he had planned for, he simply lied about it.

It is extremely serious that Burton denied in a summary to a law firm what was so clearly said and agreed upon at a meeting only 16 months earlier.

Bero had tried to prevent me from defending myself. When we came to the item, "the co-chairs' correspondence," she asked me to leave the room immediately because I was conflicted. I refused to accept her appalling conduct. A person accused of wrongdoing must be told what the charge is and be allowed to defend himself before being asked to leave.

Both before and after this happened, Bero was very aggressive and rude towards me. A board member said that she lost her authority given the way she behaved and that it was clear to the rest of the board that she had a personal grudge against me. I never understood why but it might be jealousy. I had emerged as a high-profile critic of the drug industry and conflicts of interest, which had traditionally been her domain.

I was out the door for only ten minutes. When I came back in, I was told that I was free to use my letterhead in correspondences, without restrictions, and I could also use it for non-Cochrane issues. Later the same day, Joerg and Gerald told me that other centre directors often did this, but none of them drew the ire of Wilson.

In my report to Counsel,[1578] I noted that the events in Genève were a clear case of serious tampering with the evidence and serious mismanagement of a charity. But Counsel was unprofessional. In his report to Cochrane,[1579] he "unequivocally" rejected my evidence-based conclusion "because it is a very serious allegation." This is a non-sequitur a lawyer should not make. He furthermore argued that "How one goes about drafting minutes can be a difficult task. It involves synthesising what is often a fluid, many-voiced meeting," and that Wilson undertook that task in a bona fide way, which means without intention to deceive. Counsel cannot know what goes on in Wilson's head.

Counsel's illogical way of reasoning continued. He claimed that if the minutes had been seriously misleading, the co-chairs would have immediately rejected them. I wonder if he reasons similarly in a court case. He deliberately ignored that the co-chairs knew the

minutes were untruthful and it got worse when he claimed that the board could not have approved the minutes without colluding in a large conspiracy to tamper with them.

Being a lawyer, surely Counsel must know what group pressure can to do people - it is called coercion, and it is utter nonsense to claim that this assumes a conspiracy.

Counsel did not consider the obvious explanation for the tampering: That I threatened Wilson's supreme rule, which was why he and the co-chairs were antagonistic to me.

Counsel was not impartial. Moreover, Burton had cherry picked the briefing documents he sent to Counsel. Burton's instructions to Counsel were fraudulent,[1580] with lies interjected here and there, casting me in an unfavourable light. For example, Burton deliberately misrepresented the facts when he described the dispute resolution procedure to be used if the CEO and a centre director disagreed. He could have copied and pasted the text in the Collaboration Agreement into his "Instructions to Counsel,"[1581] which would have been easy, but instead, he omitted a crucial bit. Based on this fraud, Counsel might have drawn the erroneous conclusion that I had failed to call upon the Centre Directors' Executive before I contacted the board after Wilson in Lisboa in 2018 had bullied me and another board member (see page 339). There was no such requirement in the Agreement.

Burton mentioned "allegations" of bullying behaviour and management by fear on the part of Wilson. Burton knew perfectly well that these were not allegations but facts, and he claimed there was an issue between Wilson and me as to what exactly was said and agreed in Lisboa.[1582] There was no "issue." Wilson tampered with the minutes (see page 339).

There were many other inaccuracies and misleading statements, and Burton had left out important documents in my favour. That Wilson had contributed to the binder was clear, for example, from a correspondence between Wilson, his deputy and me, related to a meeting we had in London on 9 July 2015, which Burton could not have included without Wilson's assistance. Due process would have required asking me if the material was appropriate and correct, and whether important information was missing. This did not happen even though the "Index to Counsel's Papers"[1583] showed that a response from me was "missing" in three cases.

Burton included Wilson's 2014 letter to the psychiatrists in the binder but failed to explain that I met with Wilson, Tovey, Grimshaw and Bero in Panama City where Grimshaw apologised and that Wilson and colleagues back-pedaled, saying they had been misunderstood.[1584]

Counsel was asked to assess if I had made public statements and published papers that were *potentially damaging* to Cochrane's reputation. This went too far. Many things can be potentially damaging. Cars and prescription drugs can potentially kill people but that does not make them illegitimate. My papers are scientifically robust; they have usually been peer reviewed; and no one has found errors in my research. Counsel should have assessed if I *had damaged* Cochrane's reputation. The answer to this is: quite the contrary. But the burden of proof was reversed and landed on me. It was wrong to force me to prove that I did not cause reputational damage instead of the CEO needing to prove that I did. No such proof was ever presented by anyone.

It was also wrong to ask Counsel to assess any harms I might have caused. Counsel was not asked to assess the harms Wilson had caused, including undermining me and many other centre directors and issuing statements dissociating Cochrane with my research group instead of supporting the scientific debate.

Cochrane reviews aim to clarify the balance between benefits and harms of interventions. A powerful drug causes more harm than a weak one, but usually also leads to more benefit. The more you achieve, the more harm you will cause. Counsel should have been

instructed to assess the balance between benefits and harms, both for me and for Wilson. If he had done that, and had been presented with unbiased information, and had not been biased towards those who paid him, the conclusion would have been that Wilson must leave Cochrane. Most idealistic organisations end up destroying themselves because they let the wrong leaders take over. This was Cochrane's tragedy, too.

Burton's binder mentions that Wilson and the co-chairs wrote to me in 2014 following the publication of my 2013 book and a video in which I "appeared to advocate that every patient taking psychotropic medication should stop taking their medication." This was another huge lie. I have never advocated this. The two chapters on psychiatry in the book end this way:

"I know some excellent psychiatrists who help their patients a lot, e.g. David Healy uses watchful waiting before giving drugs to first-episode patients (21). I also know that some drugs can be helpful sometimes for some patients. And I am not 'antipsychiatry' in any way. But my studies in this area lead me to a very uncomfortable conclusion: Our citizens would be far better off if we removed all the psychotropic drugs from the market, as doctors are unable to handle them. It is inescapable that their availability creates more harm than good."[1585]

I have continued to advise that we should use these drugs very sparingly and I have warned against stopping psychiatric drugs abruptly.

This statement in the binder was plain nonsense: "PG had provided his own (potentially controversial) opinions to the Court on Cochrane branded paper … thus raising concerns as to the impartiality and independence of Cochrane as an organisation." My expert report for a homicide case in Holland (see page 147) was not public but was sent to the court, and as no one in Cochrane but me had seen it, they couldn't have any views on it, so why write that my report was "potentially controversial?"

The binder claimed that Wilson issued a statement on 3 May 2018 in response to a Tweet by Anton Pottegård. This never happened.

Counsel asked Wilson and me to comment on the binder he had received from Burton. I received Wilson's undated submission to Counsel on 23 August 2018, which was amazingly untruthful, even by Wilson's standards.[1586] He also questioned my motives. When I became elected for board, I asked for the election statements for the board members, the application and CV for Wilson, and any assessments of his performance that the board had seen. I explained that I needed this information to prepare for my new assignment.

In Wilson's mind, my reasonable request was translated into: "Where does this deep animus by Peter towards me come from?" He also wrote: "Peter's main focus of resentment has always been me." This is known as the *pity me* trick, which psychopaths use. They are brutal towards others but still expect us to pity them over minor or non-existing issues.

It is astounding that Wilson, in bold letters, declared that "the pattern of aggressive language, bullying approaches and offending others inside and outside Cochrane belongs to Peter, not to me," when the evidence so clearly pointed towards himself. This is what psychologists call projection. Emotions or traits you don't like about yourself, you attribute to someone else.

Wilson's assertion that, "he only hears, records and reports what he wants to," was also an accurate description of himself, not me, who only tried to survive in the surreal narcissistic Cochrane universe Wilson had created around himself. Two months into my short stint as a board member, we got an email from Wilson saying, "I'm extremely proud of and pleased with the documents we have prepared for your meeting in Geneva; and of the

substantial work that they reflect and represent." This is short of saying, "I am extremely proud of myself." Others were not so impressed.

Wilson lied when claiming there was a longstanding and well-known pattern of aggressive communication, with bullying of Cochrane collaborators and other external stakeholders by me over many years. He gave two examples that were both highly misleading.

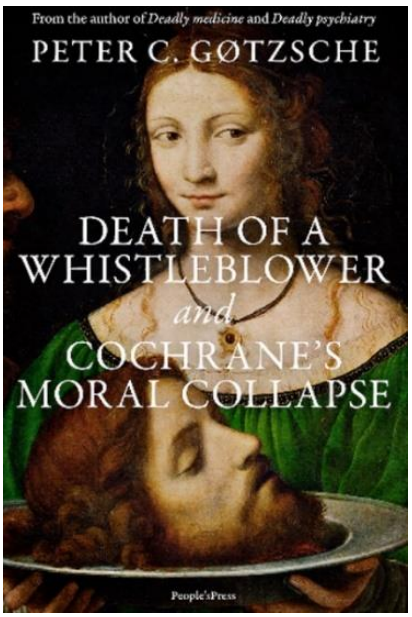
One was a letter from people who had used highly flawed methods when they postulated that mammography screening reduces breast cancer mortality by 38-48%. I documented in detail in the *BMJ* what was wrong with their methods.[1587] My deputy and I also posted a comment on our website where we concluded that the paper presented "wishful thinking and inappropriate extrapolations far beyond the data … they must have cherry-picked the data they liked." Moreover, none of the authors had anything to do with Cochrane. That Wilson was against that we published our criticism, demonstrated that he favoured scientific censorship.

The truth in Wilson's other example is the exact opposite of what he claimed. I didn't bully anyone but just defended myself against a Cochrane staff member, Julie Wood, whom Wilson had ordered to bully me! (see page 317).

Wilson's problem was that - unlike everyone else - I did not cave in to his unjustified threats. He must have known that my expulsion would be immensely harmful to Cochrane. So, why didn't he care? Of course, Wilson had hoped to be able to tell the press, avoiding any questions, that, "An independent, legal investigation has shown that Peter Gøtzsche has broken our rules, but we cannot give any details, as we want to protect his right to confidentiality and privacy …"

However, Counsel did not support him, and as I uploaded his confidential report for everyone to see, after I had been expelled, Wilson could not spin the story and pretend he had saved Cochrane by sacking me. No one would have believed him.

## The Cochrane show trial: the worst ever in academia?




"This is like capital punishment what we're doing"

*Gerald Gartlehner, former Cochrane Collaboration Governing Board member who resigned in protest*

"Industry will be elated. Oh finally, we are offering Peter's head on a platter … It's the nuclear option"

*David Hammerstein, former Cochrane Collaboration Governing Board member who resigned in protest*

On 17 September 2018, during the annual Cochrane Colloquium, which was held in Edinburgh, I was unceremoniously expelled from Cochrane's Governing Board and also from the Cochrane Collaboration after one of the worst show trials ever in academia. Wilson even got me fired from my job as director of the Nordic Cochrane Centre.

No one had ever been expelled since Cochrane started in 1993. My story is therefore much bigger than me. It is a story about institutional corruption and the rapid transformation of a prosperous democracy into a tyranny with Wilson and Burton as the leading characters. Both men displayed psychopathic traits:[1588]

"Psychopathy is characterized by diagnostic features such as superficial charm, high intelligence, poor judgment and failure to learn from experience, pathological egocentricity and incapacity for love, lack of remorse or shame, impulsivity, grandiose sense of self-worth, pathological lying, manipulative behavior, poor self-control … the image of the psychopath is that of a cold, heartless, inhuman being."

Other texts describe a psychopath as someone who is callous, unemotional, and morally depraved, with impaired empathy. Psychopaths lie easily and bluntly and violate the rules other people abide by, which I have given numerous examples of above.

I was unlucky that I came up against such personalities. It is a battle you can't win, which I did not realise in time.

Mark Wilson

Martin Burton

In my two books about the scandal,[1589] I document in detail the false allegations raised against me that were concocted before, during and after the show trial. The reason I wrote a second book was that my filmmaker, Janus Bang, wanted to make a documentary about it, *The honest professor and the fall of the Cochrane empire*, and much had happened since the first book came out. We have come quite far but are still seeking donations to finish it.[1590]

Child and adolescent psychiatrist Sami Timimi reviewed my first book about Cochrane's show trial and, as in everything he writes, Sami was very sharp and to the point:[1591]

"This book chronicles how an upside-down world is created when marketing triumphs over science; where the actual target of a years-long campaign of harassment gets labelled the guilty party ... The book stands as a detailed study in how organisations become corrupted … The death of its integrity, means that the most important institution left that could be trusted when it came to medical science, has disappeared … Indeed it was because Professor Gøtzsche was prepared to call out the lowering of scientific standards in Cochrane that the hierarchy felt compelled to plot his demise.

Gøtzsche … created many of the methodological tools used by Cochrane reviews and has never shied away from letting the data speak for itself, however unpopular the findings

might be … Gøtzsche was, and is, an inspiration to those of us who want medical practice to be as objective, free from bias, and safe as possible; but a threat to those who put commercial matters, marketisation, and image as their primary concern.

Gøtzsche's brilliance and his fearless approach earned him many enemies. He is one of Denmark's best-known researchers … His work on psychiatric drugs showing how poor they all are at delivering better lives for those who take them, at the same time as causing enormous harms to millions, has earned him the ire of the psychiatric establishment at large, including some Cochrane groups ...

Instead of congratulating Gøtzsche for ensuring the integrity of the science produced by Cochrane, they began a challenge to this truth seeker for being 'off message.' This book carefully recounts this dark period in medical science where a once trusted institution carried out one of the worst show trials ever conducted in academia. The CEO and his collaborators went about their task in a manner that mirrors how the drug industry operates ...

Leading medical scientists from all over the world expressed their solidarity with Gøtzsche and outrage at what Cochrane had done. They universally praised Gøtzsche as a tireless advocate for research excellence, a fearless critic of scientific misconduct, and a powerful opponent of the corruption of research by industry interests, and criticised the unsupportable actions of Cochrane. History will recount this as the death of Cochrane rather than the whistleblower."

John Abramson, author of the bestseller *Overdo$ed America*, wrote in his book review that the clash was between my relentless search for accuracy and completeness and Cochrane's demand for institutional loyalty and protection of the "brand."[1592] Referring to the Cochrane reviews of Tamiflu and statins, he noted that Cochrane doesn't learn from its mistakes.

A group of French-Canadian doctors wrote in the article, *Medical science integrity decapitated*, that "Peter Gøtzsche … became one of the most respected experts of his time for his critical evaluation of clinical trials and his denunciation of the corruption of knowledge by healthcare industries … This recent victim of institutional corruption defends himself with uncommon courage in a devastating book - certainly the book of the year in medical ethics. If Cochrane persists in this path, then academic independence, freedom of expression in science, and the quality of your doctor's next prescription are at stake. Academics here and everywhere must show their indignation and avoid behaving like a lookout on the Titanic bridge who would not sound the alarm"[1593]

Another book review, by Iver Mysterud, also described Cochrane as sinking:[1594] "I became absorbed in the story of one more bizarre incident after the other … What should we think of an organisation led by a handful of 'power-hungry bandits'? … Although many researchers in Cochrane reacted negatively to Wilson and some quit their jobs, Gøtzsche was alone to openly take on the fight ... in the long run, you are doomed to lose in the face of cynical power men … many people follow with Argus eyes what Gøtzsche writes and does. A slightest glitch would result in tremendous attention and media coverage. However, Gøtzsche is known not to be mistaken. Therefore, for decades he has gained a reputation as an eminent and fearless researcher who also has the heart in the right place in the encounter with abuse against patients. He tells about mistakes, dishonesty and injustice, no matter who feels hurt in the process."

On Amazon, customers had headlines such as *Death of an organisation - may the whistleblower have a long life!; A blow by blow account of Cochrane's collapse; Death of*

*scientific integrity;* and *Gøtzsche is one of the few in opposition to the so-called established 'care.'*

Other people told me I was the most well-known Danish doctor and person in Cochrane. As the book reviews indicate, I was considered a symbol of honesty, integrity and science at a very high level, and Wilson made a huge mistake by expelling me because I exemplified what Cochrane was. In 2008, former co-chair of the Cochrane Steering Group, Adrian Grant, wrote to the former CEO, Nick Royle: "I advise you to think hard about how you should reply to this. You did finish your email to Peter with an unfortunate sentence and I can understand why Peter considers this discourteous. In many ways, Peter is the 'conscience' of the Collaboration. We may find him irritating at times, but we should never ever be dismissive of him."

I was very active in promoting my research results to the public, which I felt was my duty, also because the government paid for my centre. One of my interviews, about the organised crime in the drug industry, has been seen by over one million people.[1595] I contributed substantially to make Cochrane one of the world's most trusted scientific institutions and fought to uphold Cochrane's values of transparency, rigorous science, free scientific debates, and collaboration. But instead of maintaining scientific integrity, Wilson was consumed with promoting the Cochrane brand and products and demanded censorship of dissenting views. This is detrimental to a scientific organisation and Sami was right that this was the beginning to the end of Cochrane.

The carefully staged show trial was intended to be kept secret. But in terms of justice and accountability, and for the historical record, it was essential that the meeting was recorded. Since the co-chairs, Koster and Burton, flatly rejected this when I brought it up, it was clear that they had planned for a secret process, with a predefined outcome, like during the Inquisition. No traces of the injustice were to be left behind.

I reminded the board that we had agreed earlier, after the chaotic Genève meeting, that all board meetings would be recorded to avoid disagreements about what was said and agreed. Koster said that, as the board meeting had not yet started, she did not want to engage in any such discussion.

I insisted, despite her repeated rejections, but she continued to ignore my request and tried to start the board meeting with some formalities. But tensions were running high, and Joerg Meerpohl mentioned my request and said the meeting should be recorded, as agreed on earlier. Koster interrupted him at least three times and said we should move on.

However, it was now so embarrassing that not even the steely co-chairs could ignore the requests. A long pause followed while the recording possibilities were being investigated, in another room where I was not allowed in. Twenty minutes later, Burton did not promise to record the meeting but announced that people with Mac computers could record it with Quick Time Player.

Already the next day, Lucie Binder from Wilson's office sent an email to those four board members who had resigned in protest over my expulsion requesting them to delete their recordings. But I got them from one of the resigned board members. On the 3-year "anniversary" of my expulsion, I uploaded a transcript, with my comments,[1596] and published an article about the show trial and Cochrane's demise.[1597] Maryanne Demasi published a very interesting article the same day, *The Cochrane tapes*.[1598]

As the co-chairs did not have any good reasons for expelling me, they shrouded everything in secrecy by referring to confidentiality and privacy, both before and after the board

meeting. In this way, they tried to avoid being held accountable for their actions. As an example, Counsel's report was marked, "STRICTLY CONFIDENTIAL. TO THE GOVERNING BOARD AND MR MARK WILSON. NOT TO BE DISSEMINATED ANY WIDER." The board was even told by the co-chairs that they needed to ask their lawyers whether the confidentiality extended to the fact that the review was undertaken and to the existence of the report. This was not up to the lawyers to decide, and it would violate not only core Cochrane values but what we all think justice should be about.

As Counsel's report contradicted the board's announcements of my culpability, I had no doubt that I must make it publicly available. I also needed to defend myself against the numerous lies and defamatory rumours the co-chairs set in motion after my expulsion. I therefore uploaded all important documents on www.deadlymedicines.dk so that people can form their own opinions.

During their "process" against me, the board broke every one of the most essential rules for charities and for Cochrane.[1599] The basic requirement for honesty was violated so often that I wrote "This is not true" 24 times in the transcript of the board meeting.

What ruled out any fair process was that the board did not have time to study the issues. The documents, which the board needed to carefully consider, amounted to 652 pages, the size of three books, and most of it arrived 1.5 days before the board meeting. Counsel's 39-page report arrived only 12 hours before, in the late evening of 12 September.

The discussions during the board meeting revealed beyond any doubt that the board members had not read all these pages. Moreover, the co-chairs included irrelevant factors, lied about them, and used them actively to arrive at a decision to expel me. Finally, as already noted, the information the board received was incomplete, misleading, biased or untruthful, and the co-chairs stopped all discussions when board members tried to bring relevant factors to the table that would have exonerated me.

As I wanted to have witnesses to the injustice I expected, I brought three people: Maryanne Demasi, my visiting researcher from Sydney; Anahi Testa Pedersen, a documentary film-maker who made *Diagnosing Psychiatry* (see page 166) and worked for me from time to time; and Janus Bang who did not reveal his identity to the board.

We arrived early, and when Burton and Koster entered the room, they panicked. Burton marched towards our group and said he recognised Anahi as a filmmaker. She explained that she would not be filming on this occasion. Over a year earlier, she had contacted Cochrane headquarters for interviews, but the staff had not been forthcoming.

Burton demanded that all three should leave. I explained that, according to charity rules, a board member is allowed to bring members of staff to board meetings. A good deal of back-and-forth arguments followed, and Burton left the room several times. He then said they had consulted their lawyers; that it was a private meeting; and that I did not have the right to invite anyone.

I repeated they violated the Charity Commission rules; that it was a board meeting, not a private meeting; and that I was allowed to be accompanied by staff. I felt uncomfortable because I had observed several times during my 20 months on the board that Burton either bent the rules or invented them on the spot to please Wilson.

To say the least, the situation had become hectic and confused. Burton went into another room with the board, except me, to explain what information he had received from Cochrane's lawyers. As I was a board member, it was illegitimate that Burton excluded me from the discussion.

It must have been difficult, as it took 20 minutes before they came back. Koster asked my colleagues to leave. I said that I had not found the word "private" in any of the emails I had received and made the board aware once again that they broke the charity rules.

Koster interrupted me and said they had consulted with the legal Counsel and that he had agreed that my three colleagues should leave. When I tried to dispute this, she interrupted me and said she could call Counsel. I did not accept that Counsel could trump charity rules, but she interrupted me again and said they could work that out later, which she never did.

Koster and Burton used this tactic repeatedly, which philosopher Arthur Schopenhauer has described this way: "If you observe that your opponent has taken up a line of argument which will end in your defeat, you must not allow him to carry it to its conclusion, but interrupt the course of the dispute in time, or break it off altogether."[1600]

Koster was very hostile and aggressive towards my guests, and Anahi and Janus left the room to ease the tense situation. They found Burton in the corridor talking frantically with Cochrane's lawyer on the phone: "I need to get rid of this man; how can I do it?"

Koster was very defensive and continued being arrogant at the same time. Burton told her that she needed not explain to Demasi why she was not allowed to be in the room with me. Koster was very rude to Maryanne and asked her to leave, which she did. No witnesses were allowed to the horrific show trial that was about to begin.

There are no official recordings for the first hour of the chaotic prelude to the six-hour secret meeting. However, I had a recorder in my jacket, which I left inside the room when I was asked to leave. I was given five minutes to defend myself. Koster started out by asking me if I accepted the contents of Counsel's report.

I replied it was a very unspecific question and asked her to clarify.

Koster: "Do you accept the conclusions of Counsel. I'm just looking for a yes and no answer."

I said that, as there were many conclusions, I could not say yes or no. Then, Koster asked if I accepted the report, as is. I replied that the report was pretty weird, and that I found it strange that the lawyer referred to "authority" and "eminence," for example by saying that Burton was an "eminent professor" and therefore could not have done anything wrong.

When I told Maryanne afterwards what had happened, she said they had set up a trap for me, which the recordings confirmed. Counsel falsely believed I had breached the Collaboration Agreement I had entered with Wilson, and the trap was that, if I had accepted the report, they would have found me guilty, and if I had rejected it, they would also have found me guilty because I did not accept the "evidence" and did not even understand what the Agreement meant. This is how authorities always found witches guilty 500 years ago.

The trap was really smart. As it was set up by Cochrane's lawyers (see below), it showed that Counsel's report was not "very objective and impartial," which Koster claimed.

During my short presence at the board meeting, I rejected the two main allegations raised against me. I said that Counsel agreed with me that I had not broken the Spokesperson Policy and that it was not wrong of me to contact the board when Wilson threatened to close my centre if I didn't please him. I therefore found that the "process" could have been avoided, including the expenses to the law firm.

I noted that I suspected that Wilson was behind it all; that there was a hidden agenda; and that I had good reasons to believe that Wilson wanted to get rid of me.

I asked for permission to stay in the room because we were at a crossroads for Cochrane:

"Many people in Cochrane trust me that I can do something for them because they are deeply unsatisfied by the way Cochrane is going under Mark Wilson's leadership, so this is about much bigger issues than the petty things about the Spokesperson Policy … It's not about me because it's so clear I did nothing wrong from the lawyer's report, so I actually encourage you to allow me to be in here so I can contribute to what I was elected for doing, namely doing something good for Cochrane and that means changing direction from the business-like perspective back to the science perspective, which is our whole reason for being here."

Koster did not reply but asked me to leave. It was exactly five minutes after I had started talking. I said I had some important questions I believed I was entitled to get a reply to before I left, but Koster interrupted me and asked me to leave, "given that we've wasted a fair bit of time already." However, some are more equal than others in Cochrane. After I had left, more than an hour later, when a board member expressed concern about running out of time, Koster laughed and said: "Oh, we've got plenty of time, as much as you want."

David Hammerstein said that I had not been able to speak more than 30 seconds without being interrupted. He wanted to hear my questions and asked Koster not to interrupt me.

I said, jokingly, that it was very kind of Koster to give me five minutes after I had used months on the issues. I warned the board that the world was watching what they were up to and that it was not prudent that Cochrane treated me as they did. Cochrane was in crisis, and I was just the messenger. When I said I was surprised that hundreds of pages compiled by Burton was sent to the lawyer without my involvement at all, Koster interrupted me. I then posed a direct question:

"Did you involve Mark Wilson in compiling all these papers Martin?"

Koster interrupted again: "Peter, this …"

"That's a relevant question ..."

"Peter, this is all in the documents."

"No, it's not here whether Martin Burton involved Mark Wilson … that's not stated anywhere. I am asking, did you or did you not?"

Burton nodded.

"You did. OK, that's for the minutes."

I caught Burton off guard and he immediately fired back when I asked for his admission to be minuted: "I've said nothing. And I intend to say nothing. I wish as the chair to record my objection to this, the line we're taking here. I don't agree, after all the effort that has gone into all these pages that Peter, the lawyers advised that we should ask him the questions we've asked him, give him 5 minutes and it is now 10 or 15 minutes and I think this is an abuse of process. Sorry."

Remarkably, Burton talked about an abuse of process when I asked a highly relevant question about how the documentation was compiled, which *was* an abuse of process.

I asked: "Why don't you want to answer such a simple question which is important for whether this process has been fair and equitable?"

Koster: "Peter, I think I'm going to have to ask you to recuse yourself."

Me: "This is looking more and more like a Kafkaesque process; don't you realise that? And now you've involved lawyers, so this is a semi-legal process, and yet you forbid me, against charity rules, to bring my scientist who is very good at advising people. She has advised the Minister in Australia …"

Koster interrupted: "Peter, this is not a legal process, this is not a trial."

Me: “It’s a semi-legal process. Yes, it definitely is. And I also want to know, my report that I sent to the lawyers on the 30th of August, when was that seen by the co-chairs? Was it seen before everybody else saw it yesterday?”

Koster interrupted: “Peter I don’t even want to get into a discussion about this. We are definitely going to have to ask you to leave at this point.”

Me: “This is relevant because remarkably similar letters came from senior figures … a few days after I delivered my report to the law firm, so my suspicion is that there is a connection there, that this is actually some kind of show trial I’ve been exposed to …”

“Peter that may be your suspicion, but it is not the truth, I’m going to have to ask you to leave at this point because we’re getting into issues that are irrelevant to this conversation.”

“Of course, you think it’s irrelevant …”

Koster interrupted: “If you would please excuse yourself now, I would appreciate it. We need to move on with this discussion.”

My highly relevant question about when the co-chairs saw the report, I submitted to Counsel on 30 August was dismissed as being irrelevant. After I was forced to leave the room, Koster admitted that she saw my report before the rest of the board did, and Burton revealed that Cindy Farquhar, who wrote a letter of complaint on 3 September, also knew about it because she was the outgoing co-chair that Koster replaced.

This strengthened my suspicion that Burton orchestrated the letters of complaints as soon as he had seen my report. These letters arrived to him between 2 and 5 September, and they all called for my expulsion from the board because I had criticised the Cochrane review on the HPV vaccines, published in May 2018. I shall come back to this (see page 364).

I asked: “But what are you going to discuss in relation to me because the lawyer actually exonerates me?”

Koster: “Peter, that’s your impression of it. We are going to be discussing the report as it was sent to us and the conclusions, and we were advised by Counsel that you must recuse yourself from this discussion.”

Before I left, I said: “The lawyer suggests that we should not use our letterheads if we correspond about non-Cochrane matters. That would kill the Cochrane Collaboration, at least the Cochrane centres. We apply for funding for other projects which help us survive and if we don’t use our Cochrane affiliation and letterhead, people would laugh at us, so it’s harmful for Cochrane. A lot of what the lawyer suggests is harmful for Cochrane. And I am not allowed to say anything about this, so I hope the rest of you will …”

Koster interrupted: “Peter, when you have an opportunity to discuss these issues ...”

“When will I be allowed in again?”

“You will have an opportunity to address this report in writing, if you choose to do so.”

Joerg: “When we start discussing general problems within Cochrane … it will be good to have him in the room …”

Koster interrupted ...

Joerg: “I think Peter is entitled to join in that discussion.”

Koster avoided replying to Joerg and said they would call me “if anything needs discussing.”

During the rest of the day, several board members suggested I should be called back and participate in part of the meeting, but the co-chairs wouldn’t allow this.

One of Cochrane’s 10 key principles is about minimising bias and avoiding conflicts of interest.[1601] The co-chairs were heavily conflicted. Burton, because I had documented his serious mismanagement, and evidently also Koster, as judged by her comments and the way

she conducted the meeting. It was disappointing that none of the board members said that Burton should not be allowed to participate in the meeting.

Wilson was Burton's line manager and could threaten Burton's job security as director of the UK Cochrane Centre if he didn't follow orders. This construct constituted another major conflict of interest. But Burton never recused himself. When we discussed Wilson's bullying behaviour towards other people during the board only time in Lisboa, Nancy burst into tears when she said that Burton was afraid of Wilson. Despite being conflicted, Burton dominated such discussions and quickly diverted them or ended them.

I went into the library next door where Maryanne, Anahi and Janus were waiting for me.

The meeting was held on the premises of the Royal College of Surgeons. Security staff turned up who wanted to know who Janus was, the only person the co-chairs didn't know anything about. Janus asked why. "For security reasons, in case there is a fire," a woman responded. He laughed and said he didn't believe that was the reason, which made her considerably distressed. It's not nice to be unveiled. Janus left the building, still anonymous, to join Anahi who had already left.

Next, Maryanne and I were then told that, since we were not surgeons, we were not allowed to be in the library. This was also odd because there was coffee in the room, and lunch for the board members would be served there later, also for me, and only two of the board members were surgeons. While I discussed this with security, Burton came in, with a very stern look on his face, didn't utter a word, and took away the coffee, tea, and water.

The next excuse was that an "anonymous source" had said that I didn't belong to the board meeting and that I therefore needed to leave the building. They wouldn't tell me who the liar was. I documented to security that I was part of the meeting and told them that the only reason I was not in the board room was because they were discussing something for which I had a conflict, and that I would go back later.

As they still didn't believe I was part of the meeting, I showed them Cochrane's webpage that described who the board members were. We were then allowed to sit in the stairwell outside the board room where we met with Koster during the break who looked really irked and talked to the staff, presumably about how they could kick us out of the building. She did not greet us or speak to us.

The show trial was totally unprofessional, with a lot of, I think, I feel, I assume, I don't know, but. There was virtually no discussion of the evidence and if in my favour, it was dismissed.

Burton was obsessed with my "behaviour." The words "behave" or "behaviour" popped up 127 times. He stated numerous times that I didn't agree with him, which he used to disqualify me, even though Counsel's report documented that Burton lied about the facts. The Spokesperson Policy was mentioned 42 times even though I never breached it.

Including the introductory hour, Burton interrupted other board members at least 66 times, or every six minutes, and Koster at least 27 times, particularly when they:

- said anything positive about me;
- were about to prove that an allegation raised against me was false;
- were about to prove that an allegation had been rejected, e.g. by Counsel;
- were about to prove that others had done similar things as me without being punished;
- questioned the actions of the co-chairs or Wilson.

Janet Clarkson's logic was difficult to follow. She praised Counsel's "incredible professionalism" (he was unprofessional) and said about me that, "We've got a love-hate

relationship with Peter. He can be absolutely wonderful, challenging, charismatic, innovative, incredibly intelligent, but what the hell is he doing in this precise moment in time?"

I did what I had always done, for 25 years. Later, Janet said: "I can't articulate how sad this makes me feel ... I'm not sure how much Peter is aware of the huge sense of respect and regard people do have for his work and what he has achieved and where Cochrane is, in part because of him." So, Janet, why did you not vote against my expulsion?

By the end of the day, when the going got rough and the co-chairs did not allow any discussion that could divert people from the preplanned outcome, Lamb said that they should not make a decision until I had had the chance to talk, and that they would need to genuinely consider what I had to say. But Koster was evil. She replied: "So, at this point, we want to start talking about options on the table?" Which was about ways to exterminate me.

Another tactic was to get members to submit by exhaustion. Burton and Koster were highly aggressive and focused on their task, and they were therefore not worn out, like the other board members were. Gladys Faba noted that some people were so aggressive that it did not facilitate the board's decisions about whether something was good or bad.

Janet Clarkson

Gladys Faba

If there had been any reasonable allegation against me, it would not have taken a whole day to get a majority vote. The arguments were recycled, like when you lose your way in a forest and hours later come back to where you started. Then, you are grateful if a leader takes you by the hand and escorts you out of the forest, just like in the "process" against me.

With two steely co-chairs, group dynamics ensured that the board members accepted being brushed off, as they did not wish to be "difficult." Even when they didn't agree with them, they tried to appease their leaders. As I have detailed in my two books, there were many examples where my supporters criticised some of my actions in a way they would not have done if they had not been under influence of group dynamics.

Another important lesson from studies of human psychology is that radicalisation of a group tends to become worse with time. Group members want to impress their leaders, which they do by being even more radical than them.

Radicalisation can occur quickly, which the board meeting demonstrated. In the beginning, it was not clear to the board what the process was about, and the co-chairs did not clarify it. Little by little, the witch-hunt escalated and the arguments and allegations against me became more and more extreme. As there was no reason to expel me, it became a matter of so-called bad behaviour, which can be used against anyone, like accusing filmmakers

of communist sympathies during the McCarthy era. I have never met anyone who has not behaved badly now and then; it is part of being.

In the Soviet show trials, people were accused of being enemies of the state, which ensured Stalin's firm grip on power. Similarly, the Cochrane show trial was all about ensuring Wilson's firm grip on power. Nicky Cullum said: "He's anti-collaboration, he's the enemy within." This reminds me of Henrik Ibsen's play, *An Enemy of the People*, from 1882. Dr Stockman finds out that the water in a popular bathing area, which is very important for the community's economy, is contaminated with bacteria. During that time, in Norway, it was a very serious matter to be found guilty of being an enemy of the people, as it could lead to being exiled.

A recurring theme at the meeting was that, although Counsel had exonerated me, the board referred to the charges again and again, as if I had not been acquitted. An aggravating factor is that Koster admitted that the policy documents were unclear and should be revised. It should not be allowed to find anyone guilty of having breached rules no one understands. The gem came when Koster said, referring to Counsel: "But they did feel that Peter broke the spirit of the policy if not the actual letter of the policy."

**The Spokesperson Policy: Wilson's helping hand to the drug industry**

During the show trial, David said that every single conflict between the central executive board and me was about an issue where the board took the side of the pharmaceutical industry. He warned that Cochrane was setting a dangerous precedent whereby industry representatives only had to "write a complaint to Cochrane and then Cochrane caves in under the pressure."

Fiona Godlee, *BMJ's* editor, agreed. A week after my expulsion, she wrote that Cochrane should be committed to holding industry and academia to account, and that my expulsion from Cochrane reflected "a deep seated difference of opinion about how close to industry is too close."[1602]

Wilson abused the Spokesperson Policy he had invented to sabotage my reform work in psychiatry. And he violated the Collaboration Agreement all the time, also when dealing with other Cochrane centres.

Koster lied when she said that Counsel "really felt that Peter's approach is misconceived and that he breached the Collaboration Agreement when he wrote to Dr Torrey." My letter to the funder had nothing to do with the Agreement, which is about how my centre and Wilson should collaborate. Moreover, Counsel had totally misunderstood it, believing that centres are only allowed to do Cochrane work. It is explicitly stated in the agreement that one of my tasks was to try to secure sufficient funding and in-kind support to allow the centre to deliver the functions set out for centres and its own activity plans.[1603] Finally, Counsel did not even state that I had breached this agreement in relation to Torrey; he *presumed* I had breached it.

No one could find me guilty unless they lied. Counsel wrote that my role as an expert witness in a criminal trial does not have anything to do with the functions of a Cochrane centre and that I was not speaking officially on behalf of Cochrane. This also applied to the Torrey issue, and he therefore concluded, in contrast to Wilson's email to me from 11 April 2018, that I had not breached anything: "I must say that I have some sympathy for PG's position here."

But Koster continued lying. She said that Counsel "found to some degree, yes, he did breach the Spokesperson Policy." She noted that Counsel considered the policy somewhat ambiguous; that it needed to be reviewed; and that changes should be made to make it much more clear. Given this admission, it is remarkable that no one mentioned that I had tested the policy empirically. As the results were very important for my defence, I described them in my report to Counsel, but the board didn't say a word about it.

There is no excuse for not having read at least the first three pages in my report. I explained on page three, under the heading, *The Spokesperson Policy is highly ambiguous*, that it cannot be used to discipline Cochrane contributors or to tell them they have violated it. It is inconsistent, which can lead to opposite conclusions in similar cases depending on which parts in the policy one focuses on.

I described in my report that, in the summer of 2018, I asked 24 people (21 replied and they were all familiar with Cochrane issues) to read the policy and decide if I had violated it in the three recent cases, all related to psychiatry. These were the Torrey and Loonen cases, and a tweet by Anton Pottegård who noted that I had invited people for a symposium about psychiatric drug withdrawal (see page 185) and asked if I had distinguished my personal views from those of Cochrane. Without consulting with me first, Jo Anthony from Wilson's office had encouraged Pottegård to submit a formal complaint to Cochrane. I could have told her that Pottegård is a well-known troublemaker we should ignore. He never submitted a formal complaint.

In my email to the 24 people, I did not reveal anything about the dispute with Wilson and kept a neutral tone. I asked them if they found the policy unambiguous and easy to interpret in relation to the concrete cases, and if they thought the policy ought to be improved.

Only 4,2, and 1 people, respectively, felt I had broken the policy in the three cases; only 3 found the policy unambiguous and easy to interpret; and 18 felt it should be improved.

I had asked for comments, and they illustrated how utterly hopeless and damaging Wilson's policy was.[1604] Here are a few:

About my letter asking why so many people with schizophrenia died so young, one wrote: "If such questions cannot be communicated directly by Cochrane centres, then it is time to discuss to close Cochrane as a global organisation."

About my role as an expert witness in the Dutch homicide case, people wrote: "It is clearly indicated that this is your evaluation, not on behalf of Cochrane" and "You explicitly state that you speak on behalf of yourself and not on behalf of Cochrane."

About our invitation to a seminar about withdrawal of psychiatric drugs, one wrote: "I can't see any statement that expresses Cochrane views."

About the Spokesperson Policy, people said: "I think that 'Cochrane-related issues' might be interpreted in different ways;" "The document ignores the reality of who we are and what our history is;" "The difference between speaking on behalf of and stating one's affiliation is not clear;" and "It is as unclear as it can be."

People had many comments about if the Spokesperson Policy ought to be improved:

"The lack of respect for the thousands of contributors under local conditions who earn the money for the existence of the Collaboration is striking;"

"It seems that 'the views of the Cochrane Collaboration' almost exclusively represent the established view, and as such Cochrane loses its ability to set in motion the drastic changes that are needed in modern health care;"

"The request to start every public statement with a declaration that this is 'Cochrane' or 'personal view' would generate a rather ridiculous picture for the public;"

“Cochrane is a centralised organisation where there is no general trust from the leadership that local directors behave well. The effect would be devastating, moving for example my reputation from the current perception of a respected authority in relation to methodological issues on a national level and beyond, to an employee of an office in London with no visible competence on the academic scale;”

“The ambiguity causes unnecessary, destructive conflicts and it is used deliberately by outsiders to further their questionable agendas;”

“The Cochrane Spokesperson policy, in its current form, requires far more than what is standard from other respected organisations and institutions. This is counterproductive;”

“I cannot understand at all the hysteria about the issues and why Cochrane is so ‘afraid’ of what could happen to their image. You always get the science right when you communicate, so ideally, Cochrane's organisation should support your (and others’) conclusions;”

“The policy should aim much more at ensuring academic freedom ... Cochrane should aim more at making it clear that there is a plurality of opinions and ensure that these opinions are based on rigorous research, instead of pushing a corporate agenda of pretend-agreeing;”

“An easy step could be to make it official Cochrane policy that unless a view is EXPLICITLY stated to be the view of the entire Cochrane Collaboration it should not be seen as such;”

“I don’t understand why the ‘burden of evidence’ seems to have been reversed here. It is not very logical that you have to declare that you are NOT representing the Cochrane Collaboration. It should be the opposite, that only when you are representing the Cochrane Collaboration you should declare this very clearly. Otherwise it will not be possible for anyone, ever, to state anything without the risk of breaching the very vaguely-defined Spokesperson Policy;”

“The policy is ambiguous. This can result in researchers involved in the work related to Cochrane not fully engaging in all processes of their work (e.g. communication, collaboration, data collection) out of concerns of inadvertently violating the policy. This would of course be an unfortunate consequence and one that is not in the interest of Cochrane.”

It is hard to believe, but the Spokesperson Policy was even worse as a draft, which I commented on in 2014.

It would be very awkward to be forced to say or write every time in an academic debate when you don’t agree 100% with a Cochrane review that you are speaking in a personal capacity. You might not even know that such a review exists.

**Counsel’s praise of those who paid him**

Danish journalist Bente Bundgaard interviewed me for our medical journal. She found Counsel’s report “amusing,” with its priceless pearls of denial. If you pay a law firm to write a report about issues you have with another person, you are not likely to be criticised.

Several board members said they found it problematic that it was often impossible to know who in the triumvirate - the CEO and the co-chairs - was behind ideas, directions and tampering with the minutes and other evidence. Well, Wilson was behind everything. The co-chairs didn’t do anything of importance without his prior blessing.

Koster said during the show trial that Counsel found Wilson’s response to me “sincere and reasonable;” “wholly professional in his approach to Peter with respect to historic issues,” “Wilson acted properly” (even when he didn’t); “Counsel was impressed by [Wilson

and Burton's] professionalism, integrity and dedication to Cochrane." By all means; they don't show their worst sides when being interviewed by a lawyer.

Koster claimed that Burton's binder to Counsel was made in good faith; that he was wholly impartial; and that Counsel did not find any credibility to any of the accusations I had raised about Burton's master-minding certain things and tampering with evidence. This was odd, as I had documented in my report to Counsel that Burton had done just that.

Koster even claimed there was no evidence to support my "accusations" of bullying behaviour by Wilson! This is like saying there is no evidence that Putin is a war criminal. She had no problem glossing over the fact that Counsel dismissed Wilson's bullying behaviour in Lisboa as an "isolated incident." She said it was wrong of me to bring this up at the board meeting and that the allegations were serious. War crimes are also serious, and it wasn't me but Joerg who brought up Wilson's bullying behaviour, as he was also bullied. And, as already noted, it was not an "allegation." It happened, in front of four witnesses.

Even more absurdly, Marshall asked whether my "allegations" against Wilson would be in breach of the code of conduct for trustees. If we adopt her line of reasoning, no one could ever criticise the CEO for anything.

Counsel "wholly rejected" my proofs of Wilson's management by fear, and Koster added that trustees are supposed to make sure there is an environment that is good for the managers to work in. This issue was brought up repeatedly, especially by Marshall. No one said it was also the board's responsibility to stop Wilson bullying and harassing people. Many centre directors and other senior leaders told me about their concerns with Wilson's management by fear, but they were afraid of speaking up for fear of retribution.

David criticised Counsel for his value judgments. Burton also talked about eminence, but in a different way. He argued that "as a trustee of Cochrane, as a member of Cochrane, as a senior centre director of a very eminent centre," I did not have any freedom of speech. This ignores that eminent researchers became eminent because they spoke up and had scientific freedom to pursue their 'controversial' ideas.

After Koster's affectionate praise of the Great Leader, Nancy said that there was a lot Counsel didn't know about. Yet, he concluded that Wilson acted in the best way although there was other information that he didn't. She wondered how Counsel could make an educated judgement when the information given to him was incomplete and biased.

When Nancy asked how this other information should be used, Koster said, "Let's focus on this report and the facts here." Facts? This was a bad joke.

Nancy said that there were bigger issues than letterheads, massive issues that weren't good. Koster adhered to her standard strategy saying that the bigger issues would be discussed later, which of course never happened. Great Leaders are untouchable.

But Nancy was persistent. It made no sense to her that I was singled out for not following the agreements (which I had, see above), when half the centres didn't follow them. She wondered why Counsel made a conclusion about me and not the rest of the people.

Koster didn't respond but interrupted her. When Nancy persisted, Koster interrupted her again: "I think we have to focus on the specific behaviour that Peter has." Brilliant. I did what everyone else did or would like to do if they dared challenge the Great Leader, so I must disappear. Elementary logic for civil servants in dictatorship states.

Tracey Howe adopted the co-chairs' tactic: "I think we need to be very specific on the documentation that we've got. Anything else is hearsay." By all means. What had not been carefully concocted, manipulated and lied about by Wilson and Burton was hearsay and irrelevant. Joerg grilled her a little later: "It's a bit like looking at published trials and ignoring

unpublished trials … as board members, our responsibility goes beyond judging what's in front of us."

Very rarely, a friendly board member tried to distract the misanthropic ladies from their witch-hunt, which they enjoyed. Faba asked people to respect the diversity (which is one of Cochrane's core principles) and said that people have different ways of thinking and behaving and that the board needed to be very tolerant and receptive. When David supported her, Koster added spitefully: "Without being babysitters."

Nancy said that "No one was babysitting him before he was on the board."

**Our criticism of the Cochrane HPV vaccine review was unwelcome**

The key reason why I must disappear was that I threatened the Great Leader's dictatorship role; wasn't afraid of him; and even spoke out about his misdeeds.

In May 2018, the long-awaited Cochrane review of the HPV vaccines was published,[1605] seven years after the protocol came out, which is a remarkably long gestation period for an important review. Two months later, only 17 days before the show trial, my PhD student, Lars Jørgensen, Tom Jefferson and I published a criticism of the review.[1606]

The Cochrane review was disgraceful. It had missed nearly half of the eligible trials and at least 25,000 females and was influenced by reporting bias and biased trial designs. Moreover, the authors mistakenly used the term placebo to describe aluminium-based adjuvant comparators, even though GlaxoSmithKline had stated that the adjuvant causes harms, which I and others have also documented.[1607]

The Cochrane authors overlooked several adverse events and failed to mention that several trials did not report them for the whole trial period. Even deaths were misreported, and there were many other problems that could have been avoided if the authors had looked carefully in the journal publications they used or in the freely available clinical study reports on GlaxoSmithKline's trial register that they assessed.

The authors cited many observational studies to support their idea that the HPV vaccines do not cause harm. They did not cite a highly relevant study from the Uppsala Monitoring Centre that found far more serious neurological harms with the HPV vaccines than with other vaccines (see page 284).[1608] They did not investigate either if the trials they included reported such harms but just noted that EMA had dismissed any causal relationship. This means that the Cochrane authors trusted the vaccine manufacturers (see page 278).

The Cochrane authors assessed the impact of industry funding, which was absurd as all the trials they included were funded by vaccine manufacturers.

The Cochrane editors had turned a blind eye to the fact that far more than the allowed 50% of the 14 authors on the review protocol had major conflicts of interest in relation to HPV vaccine manufacturers.[1609] Many of them were removed after outsiders had protested, and the review had only 4 authors. The primary author, Marc Arbyn, had several financial ties to the vaccine manufacturers, which he failed to declare. My research group complained about this,[1610] and our criticism was deferred to the Cochrane funding arbiters, which led to this amusing comment in the *BMJ*:[1611]

"Asking them to arbitrate may not be seen as a perfect answer, given that the original declaration of interests in the HPV review said that its authors had been approved by the same committee, 'based on stringent Cochrane conflict of interest guidelines.'"[1612]

The funding arbiters resolved that Arbyn had not breached the policy because he had not gained personal financial benefit and because the support was provided through institu-

tions.[1613] Tom pointed out that “the cash comes from sponsors even if it is routed through the North Pole [Santa Claus] and Mother Teresa of Calcutta.”

Both Tom and I had warned Cochrane beforehand. I told Cochrane’s Editor-in-Chief, David Tovey, already in 2016 that, "You must be very, very careful with this review. We are also working on this issue, and we are using clinical study reports, which are far more reliable than the published trial reports." He listened attentively but nothing happened.

The Cochrane Empire hit back. Wilson had his brand to protect, and a week after we published our peer-reviewed scientific critique of the Cochrane review, we were heavily attacked by Tovey and his deputy, Karla Soares-Weiser, who published a 30-page comment on the Cochrane website.[1614] They seemed to display Wilson’s censorship. They wrote that public confidence may be undermined, if scientific debates are not undertaken in an appropriate way, especially when they take place in public. They claimed we had made unwarranted allegations and had provided an inaccurate and sensationalised report.

They also doubted the rigour of the peer review and editorial work by *BMJ Evidence-Based Medicine* where we had published our criticism. This upset its editors who asked the Cochrane editors to be concrete and invited them to publish their response in the journal. They didn’t do this of course, as they would have lost the battle. They preferred to publish their reply on the Cochrane website, where we could not reject their arguments, as we did not have access to this site. This is exactly how the drug industry operates.

The affair illustrated the moral decline in Cochrane. The review authors did not respond to us, which is the appropriate thing to do. Instead, Cochrane used the strategy that Schopenhauer calls “Appeal to authority rather than reason.”[1615] This was warfare, protecting the wounded Cochrane flag.

People prefer fake answers for uncertainty. All over the world, the Cochrane editors’ criticism of us was interpreted as the final word in the debate. But they had not addressed our most important, highly warranted criticism. And after we had done further detective work, we published an even stronger criticism, four days after my expulsion.[1616]

Our criticism was based on data we had studied carefully for over two years. We worked with the clinical study reports we had obtained from EMA and had a unique knowledge about the trials. We are likely the only ones who have read 60,000 pages of study reports. In an article by Bente Bundgaard in our medical journal about this conflict, *Cochrane vs. Cochrane*, my centre was described as being exceptionally trustworthy.[1617]

The Cochrane review did not find an increase in serious neurological harms. We did and published our review in Jørgensens’s PhD dissertation and in a medical journal.[1618]

Remarkably, *HPV* appears 48 times in the transcript of the board meeting. The board’s statements that my criticism of the Cochrane HPV vaccine review played no role for my expulsion are untruthful. Wilson’s extermination plan was already laid out, but it did play a role for Burton, as his task was to convince the board.

I explained in the board material, that our paper was published on a Friday, and that I had clarified to the first author of the Cochrane review, Marc Arbyn, copying Tovey, already on the Monday why I had been unable to tell him about it. I was on holiday and didn’t even know the paper had been accepted for publication, as this information was only sent to my PhD student.

It was the board’s duty to know about this, but they didn’t. In contrast, they knew about the misleading comment Tovey and his deputy published on the Cochrane website on 3 September:[1619] “We regret that the authors, who are all members and officeholders within

Cochrane, did not share their analysis or the conclusions and criticisms contained in the *BMJ Evidence-Based Medicine* article before publication." They published this comment in bad faith because Tovey knew it wasn't my fault that we did not inform the Cochrane authors and that it had been my intention to inform them in advance. Yet again, I am convinced that Wilson ordered Tovey to do the dirty job for him, as this was not how Tovey was, and he left Cochrane soon after this.

The misinformation from the Cochrane editors was spread to everyone in Cochrane using general email lists like centres@lists.cochrane.org.

It was devastating for me that the board had not done its homework. Three of my supporters at the board, Joerg, Gerald and Nancy, condemned me heavily, not knowing I was innocent.[1620] We had contacted the Cochrane review team in advance of the publication of our criticism many times. Tom had sent essential data to the authors and tried to help them avoiding bias in their review, but he did not get any feedback.

Other board members were even harsher. Howe said we had undermined the author team, the review group "and the whole of the Cochrane processes … that's an attack on the organisation really."

Marshall was happy to betray the trust of the millions of women interested in knowing the full scope of harms and benefits of the HPV vaccines to prevent a bit of embarrassment of authors who published a substandard Cochrane review that did not meet the needs of people consulting Cochrane to make "Informed decisions," part of Cochrane's motto.

Lamb called Cochrane a "broad church," but other board members argued that we should all speak with the same voice, which is not a broad church, but orthodoxy.

Marshall, Lamb and Faba said we should have addressed our criticism internally first. But there are no Cochrane rules demanding this. People who think so have defined Cochrane as a social club. The board perceived the clubbiness as positive, but it is ruinous for a scientific organisation. In science, there can be no compromises when loyalties clash. Moreover, Cochrane processes for handling criticisms rarely work. My record is five years (see page 329) and it took 19 months for my colleagues in Pamplona to get their criticism of a Cochrane review of methylphenidate for ADHD published as part of the review. My research group also criticised it (see page 158), and it was so poor that it was withdrawn. One of the critics asked the Editor-in-Chief and the editor for the review group to issue a press release, which they refused. Like a drug company, Cochrane only publishes positive messages. This is Wilson's "branding" and "trusted evidence."

Sometimes, relevant criticism of a Cochrane review is never published as part of the Cochrane review even though this is obligatory. I have experienced this several times, e.g. for an embarrassingly flawed review of drugs for dementia (see page 169). A comment made by Lamb meant that if a review group refuses to publish relevant criticism of a Cochrane review from a board member, and the member goes public to serve the patients, that member would need to resign from the board!

An argument brought up repeatedly was that science should not be criticised if people had used a lot of time on it. Marshall said: "Going external is really cutting out from underneath the people who have spent such a huge amount of time doing the systematic review." Marshall thinks that someone's bruised ego is more important than ensuring that Cochrane's systematic reviews are rigorous and can stand up to scrutiny.

Burton argued that if board members disagree with a board decision, they will need to resign from the board and Marshall agreed: "You can't say the others all voted for it, but I was against it." However, the Charity Commission for England and Wales specifies in its

document CC27 that if trustees strongly disagree with a decision, they can ask for their disagreement to be recorded. Since minutes from charity meetings are made public, board members can argue for their views in public, even though a majority have other views.

Unbelievably, many comments made by board members implied that scientists cannot be board members, and that we should prioritise protecting the reputation of Cochrane over having a free public debate about the science.

Faba misunderstood the nature of Cochrane. It is not a policy setting organisation, and in science, there are rarely clear and exhaustive answers, which is why free debate is important. Moreover, Cochrane is not about having one position about an intervention; Cochrane should have no positions but just convey the facts.

Criticism of Cochrane reviews should be applauded and Cochrane even has an annual prize for it: "Cochrane values constructive criticism of its work and publicly recognises this through the Bill Silverman Prize ... with a view to helping to improve its work, and thus achieve its aim of helping people make well-informed decisions about health care."

Even the Spokesperson Policy encourages criticism of Cochrane reviews: "Cochrane contributors may sometimes be asked or wish to comment on published reviews. In doing so they can speak freely, including expressing views that are critical. This is in line with Cochrane's established tradition of academic and scientific debate."

This is hypocritical. I did what the policy encouraged, in relation to psychiatric drugs and the HPV vaccines and was thanked for my efforts by being expelled.

Nancy remarked that she would not criticise anything publicly, as she would be afraid of being treated like me. She also wondered why my actions always seemed to come to the board's attention while others' actions didn't, even though they did the same thing.

During my short presence at the board meeting, I noted that Wilson and Tovey had recently exonerated one of their own staff for having done the same as I did and I had asked Burton to send two documents to the board that were very important for my defence.[1621] One was a complaint by Tom that Toby Lasserson, an employee of Wilson and Tovey, had possibly broken the Spokesperson Policy in a Cochrane editorial from 4 August about the Cochrane HPV vaccine review. The other was the reply to Tom by Wilson and Tovey from 3 September, which exonerated Lasserson. I explained to Burton that these two letters were crucial for understanding how Wilson interpreted the Spokesperson Policy.

Burton responded with a nonsense diversion: "We have acted at all times on the advice of our lawyers." My request had nothing to do with legal issues. Burton refused to send the letters to the board because he didn't dare go against Wilson. They totally undermined the idea that I had broken Wilson's Spokesperson Policy at any time.

I didn't dare send the two letters to the board myself because I had been told I should not write to the board, and because Wilson had threatened to close my centre. Instead, I photocopied them, to hand them out at the meeting.

But as soon as I started explaining what they were about and that Lasserson had definitely come up with personal views in his editorial, without any disclaimer, I was interrupted by Koster: "I don't think we want to get into these because they weren't part of the materials that were given to everyone." Catch-22 again. The proof of my innocence had deliberately been held back! Stalin would have been proud of Burton, Koster and Wilson.

I insisted and said that Wilson and Tovey had argued in relation to Lasserson that such views did not represent Cochrane's official policy unless it was explicit in the text. This is

what I had always argued. But in *Animal Farm*, some pigs are more equal than others, particularly if they are close to the leading pig, Napoleon.

Koster interrupted me again, with untruthful remarks. She claimed I had said I had submitted this information to Counsel, and that she thought everyone had read it. I could not have submitted the information to Counsel, as it only became available four days after the deadline for the submission of my report. As it had taken Wilson and Tovey one month to respond to a simple question posed by Tom, the delay looked deliberate, to ensure that I could not make their exoneration of Lasserson part of my defence.

During the discussions of the HPV vaccine affair at the show trial, David was the only reasonable board member. He did not buy into the idea that my behaviour was horrible because I had not informed the Cochrane authors about our upcoming criticism. He was also the only one who noted that there were conflicts of interest related to the HPV review; that the review was problematic; and that our criticism of it was important for my expulsion:

"This is all very depressing … what people will see is the HPV criticism will be the straw that broke the camel's back ... I think that [Peter's] exclusion from Cochrane is something he is prepared for and it's going to have a great cost and unfortunately, there's a whole bunch of other issues, that have nothing to do with Peter, that I found out about, that are kind of being swept under the table … Cochrane is not adhering to a lot of its basic principles of transparency and conflicts of interest and things like that."

Burton tried to eat the cake and have it at the same time: "We're not going to discuss science" but then claimed that the Cochrane editors had rebutted our paper and that our criticism was not correct. He said that there is "a degree of 'hyperbole', overstating the case … The existence of the paper is bad enough, but it was immoderate as well." Burton misrepresented the issues. Our criticism was appropriate and relevant.

David noted that Lasserson's editorial was a clear recommendation to use the HPV vaccines, with no disclaimer or reservations about the problems with the science, and that Cochrane's knowledge translation was done in an exaggerated way, using people as external experts that had conflicts of interest with GlaxoSmithKline. He hit the nail on the head again: Cochrane's process for relevant scientific criticism didn't work; Cochrane had become a marketing machine; and the drug industry would gain the most from this.

Cochrane's PR was shameless. Their announcement of the review under "News" included a *Science Media Centre roundup of third-party expert reaction to this review*. Six experts were cited - all from the UK, although Cochrane is an international organisation. Two had financial conflicts of interest with the HPV vaccine manufactures. A third was responsible for vaccinations in Public Health England that promotes the HPV vaccines. The experts highlighted the "intensive and rigorous Cochrane analysis," and that "the vaccine causes no serious side-effects."

Jo Anthony, Cochrane's Head of the Knowledge Translation department, had wanted Juan Erviti, editor in the Cochrane Hypertension Group, to promote the HPV vaccines in Colombia. Because of his impressive achievements in Spain, Wilson had invited him to join the group, which he did, but he did not understand why Cochrane felt its HPV vaccine review was so important. At the Cochrane Editors' meeting in Lisboa in March 2018, the editors were much against making recommendations, but Cochrane headquarters did not respect this and had created a lot of activity on social media. As it turned out, Erviti was not chosen for a part-time editing job with Cochrane headquarters because his views were similar to those of David and me about what Cochrane should be doing.

In 2016, Cochrane received $1.15 million from the Bill & Melinda Gates Foundation. Bill Gates is known for being very industry friendly and supportive of patents, and one of his major projects was propagating the use of the HPV vaccines throughout the world.

Many people told me they lost their high regard for Cochrane reviews because of the HPV vaccine review and the way Cochrane marketed it, like a drug company.

**Burton orchestrated letters of complaint and pathetic amateur theatre**

As noted above, three remarkably similar letters,[1622] which all called for my expulsion from the board because I had criticised the Cochrane HPV vaccine review were sent to Burton between 2 and 5 September, immediately after I had submitted my report to Counsel on 30 August where I had documented Burton's maladministration.

They were sent more than a month after we published our criticism on 27 July, and to the board, not to the Editor-in-Chief, which would have been the correct thing to do. The likelihood that these were chance events is miniscule.

One was from the Cochrane editor of a mental health group, Geraldine Macdonald, and two were from previous co-chairs of the board, Cindy Farquhar and Jonathan Craig. These letters were so suspicious that the board discussed at length whether they had been orchestrated by Burton. I have no doubt that this was the case.[1623] It is a grave offence, like when the police plants evidence at a crime scene. Burton was caught to such an intent that he lost his mind. When questioned, he stuttered excessively, talked gobbledygook, contradicted himself, lied, interrupted, said he couldn't remember, and got red-faced when Nancy said she knew for a fact that Burton "pursued someone to submit a letter."

If there had not been any problems, this discussion could have ended in a few minutes, but it lasted half an hour.

At one point, something extraordinary happened. The board, which was usually very talkative, with many interruptions and people talking on top of each other, sat in silence for a full 15 seconds. Despite opposition from Burton and Koster, Nancy didn't give in but kept saying that she knew that one person had felt pressured and pursued to write a letter.

However, the group pressure, particularly when the leaders are against you, influenced her and she said to Burton: "But maybe if you can really confirm, that these other letters were not pursued, then I would be OK." This is like saying, if you didn't murder six but only one, I would be OK with that.

Amazingly, Koster continued to say that the letters were not orchestrated, although she had no first-hand knowledge of this. If it had been a court trial, such a statement would have been dismissed. But this was Cochrane, in all its absurdity.

Burton no longer denied that he had orchestrated the letters but attacked Nancy, accusing her of bringing this up to discredit him, and he tried to subvert the discussion by calling on "expertise," as if this could get him off the hook.

Being desperate, Burton started speaking for a very long time (626 words), confusingly and incoherently, saying "you begin to doubt your own sanity and your own memory" and "If I've done anything wrong in all of that then I apologise, I do not recognise this description of what has gone on, but I am beginning to doubt my own sanity here."

This is a crucial moment. Burton had been raving about the issues with the letters for quite some time and was now close to cracking. He suddenly changed subject and spoke about a meeting in Genève, which was a totally irrelevant diversion, and gave names of two co-chairs that had never been co-chairs.

He tried to blame me and arouse sympathy by saying how many hours I had cost him, playing the psychopathic "pity me" card.

Lamb dismissed Nancy's revelations about Burton saying they couldn't deal with vague generalities. This was immensely hypocritical. Nancy had said she could prove Burton's wrongdoing. And I was expelled based on vague generalities, the "bigger picture" and my "bad behaviour."

A fourth letter of complaint might not have been orchestrated by Burton. It came much earlier than the other letters, from Jo Morrison, the editor who approved the Cochrane HPV vaccine review. When I responded to her complaint, I wrote to Burton:

"You say that the complaint … was sent to you as co-chairs of the Governing Board and that you therefore intend to share the letter with the Governing Board prior to the next board meeting. I believe this is not the correct procedure. Anyone can send a complaint to the Governing Board. This does not automatically mean that it is then also the Governing Board that should deal with it. The Governing Board deals with strategic matters, not with day-to-day matters, which this is an example of. According to the Cochrane Governance Structure Flowchart, Morrison should have submitted the complaint to Editor-in-Chief, David Tovey. I therefore copy this email to David who is the person that should deal with the complaint."

I got nowhere. Burton was obsessed with rules but always made exceptions when they would not produce the predestined outcome. When Tom complained about Lasserson, he sent it to Wilson and Tovey, and Burton said at the board meeting that this was appropriate because they were his line managers! But for me, other rules always applied. I felt like Boxer, the horse in *Animal Farm*, that worked itself to death because it had done so much for the pigs that didn't do productive work.

Burton argued that since the letter writers had complained about me in my role as a trustee, Wilson could not deal with them. This remark was blatantly false. Morrison wrote absolutely nothing about my role as a trustee. Joerg supported me pointing out that one of the other letter writers addressed me as a scientist, not as a trustee.

Koster responded that trustees should be held to a higher standard, which was why these letters were sent to the co-chairs. This remark did not make any sense. Like Burton and Wilson, Koster often invented spurious excuses or violated the rules when someone backed her into a corner. This time, she stopped the meeting for lunch.

After the board's discussion of the letters, the only decent action would have been to stop the "process" against me and declared it a mistrial. But the co-chairs continued. Despite Burton's insane ravings, they went for the kill through exhaustion and group pressure.

During the lunch break, David told me that Burton had changed tactics and would no longer base my expulsion on the Spokesperson Policy but on my "behaviour." Joerg and Nancy told me the situation was very uncertain. The co-chairs looked for a paragraph they could use, and the board discussed the consequences of unleashing the guillotine. Where would the head end?

There were two interesting head-to-head conversations about the orchestrated letters when most people were out the board room, which involved Nancy, Burton and Koster. Their discussions were unfocused, confusing, contradictory, and mysterious, like "he was sending me work emails so there was no handling," which is a non-sequitur like, "the sun was shining so there was no burglary." Burton said that he rang Paul Garner but also that Garner rang him. Garner felt he had been handled but this was explained away by saying he was ill,

although it is extremely rare that an illness can make people that confused. More likely, Garner realised it was a bad idea to complain about me.

It is not even clear how many letters that were involved, and Burton did not inform the board about it, but at least six persons seem to have been involved. This is the man that could not possibly have done anything wrong according to Counsel because he was an "eminent Professor."

During the board meeting, I knocked on the door twice. The first time I asked Burton for permission to get my jacket, which was granted. I therefore did not foresee any problems when I knocked again, after four and a half hours. I wanted to tell the board that I would go back to the hotel and that it would take some time to come back if they needed me.

It might have been the worst possible moment that I disturbed Burton. He was very tense and aggressive, as he was uncertain if the board would expel me. Without even asking why I knocked on the door, he exclaimed: "You cannot come in here!" and tried to block the door physically. Instinctively, I pushed open the door to deliver my message to the board.

Burton used this in a kind of pathetic amateur theatre aimed at depicting me as a violent person. He exclaimed:

"Don't push your way in, don't push me."

I said that I only wanted to tell the board that I would no longer be waiting outside the door, and that Burton would not allow me to deliver this message.

Burton lied about what happened. He said I had dirtied his shirt and bruised his arm, and asked if he should call the police. Koster asked if he needed some ice for the non-existing injury, and Burton agreed. Nothing happened, and Burton said twice he was fine, but he nonetheless spoke about "damage and assault" and about having the non-existing bruises photographed. Marshall, Koster, and Howe called my behaviour unacceptable and Burton called it "grave." It was utterly ridiculous and psychopathic.

What happened is similar to what often happens in closed psychiatric wards. You push people over the edge and then use their "bad behaviour" against them.[1624] I had been under intense stress for several months, which disturbed my sleep. Before this, Wilson had harassed me for years, which I had taken calmly, as I had no respect for him at all.

Since the board meeting had dragged on for so long, I assumed the co-chairs looked for excuses to expel me that I was not allowed to defend myself against. I was therefore very frustrated when I decided to go back to the hotel without having got any feed-back. I even considered going back to Denmark, as I had no doubt what the verdict would be.

As for bad behaviour, I consider it seriously bad behaviour that the co-chairs didn't contact me but kept me waiting and ignored me when we met outside the boardroom, as if I was a leper. I was still their colleague, but in their mind, I had stopped existing.

Only one board member displayed any empathy for my situation. Clarkson realised that the little scene at the door represented my frustrations.

Burton said that normal behaviour would be to knock on the door, ask, and tell people I was about to leave. But he wouldn't give me the opportunity and tried to close the door right in my face.

As always, Marshall was worst, "there's no reason why we can't call the police," and when she said she found my behaviour unacceptable, Koster added "Exactly," which looks innocent when written but she has a razor-sharp way of saying it that cuts through walls.

**Me Too: evil and false allegations of sexual harassment**

Marshall's wickedness was second to none. She claimed that my relationships with staff were destructive, and when Nancy asked how she could know that, she replied: "Because that is what Counsel has said." Which was a lie. Counsel said nothing to this effect.

In relation to a discussion about whether it was appropriate for Cochrane researchers to criticise the scientific work of other Cochrane researchers publicly, Marshall suddenly said:

"I guess I'm sitting here and reflecting on the Me Too movement ... while I am personally deeply impressed by the things that Peter has done scientifically, it does not change the fact that he has behaved in a way that I believe breaches our expectations of people around this table."

Cullum and Burton also contributed to spreading this evil insinuation. When Nancy praised me for my work on mammography screening, Cullum interrupted her and spoke about Me too, and when Burton lied and said that, according to Cochrane's lawyer, there was no doubt about my "grave behaviour," he added, just after these two words: "To carry on the Me Too analogy, you know, Kevin Spacy was a great actor he did wonderful work, you know, this is not about the good things … lots of people who do bad things, do lots of good things as well. Sometimes there's sufficient bad stuff there, you've just got to call them out."

This is significant because Burton used the same wording about calling people out in his public hate speech about me four days later.

Marshall said that it was always the right thing to do to stand up to bullies, no matter how much genius they have. She spoke a lot about my bullying of people although I never bullied anyone. To bring Me Too into the picture was deliberately designed to impugn my character and it became part of the board's false narrative. What was perhaps most remarkable is that not a single board member tried to stop Marshall.

When Faba asked why the board should decide what happened in a Cochrane centre, as the centres were independent, Burton responded by talking about sexual misconduct again.

The people who stabbed me in the back were Burton, Koster, Marshall, Howe, Ray, and Cullum. It spoke volumes about Cochrane's moral collapse that Marshall and Howe became co-chairs of the board later. In the morning, both at the hotel and before the board meeting started, Marshall was extremely friendly with me, talking about sailing, wind-mills, and landscapes in New Zealand where she was from and asking me what I had seen when I was there to lecture six months earlier. I got the impression that she supported me, but she was the most wicked, two-faced person in the board room. I do not understand such people.

Marguerite Koster

Nicky Cullum

Burton and Koster were also evil, but they didn't exactly hide it. I have not been able to find an authentic photo of Koster, only a photoshopped one that depicts her as a kind person, many years younger than she was.

**How can we kick him out and what are the consequences?**

Many board members were in great doubt about what to do and what the consequences would be. Burton thought that the unjustified expulsion of one of the most well-known persons in Cochrane and one of its greatest contributors could be managed by proper PR. This hubris showed his huge disrespect for other people.

As when a murder has been ordered by a mafia boss, Burton did not dare report back to Wilson that he had not ensured the preplanned outcome. Five hours into the meeting, in all his eagerness to discredit me, he desperately said, "What happens if we just stop here … What do we really think Mark is going to say?"

My four supporters tried to prevent the inevitable; their arguments were convincing; and they warned, over and over, about the unpredictable and potentially very serious consequences of expelling me. Joerg said that the time "you guys will spend on managing Peter once you kick him out will be way more than managing him while he is in the collaboration." Nancy repeated that Counsel did not find I had broken the Spokesperson Policy, but Burton interrupted her and lied blatantly, claiming Counsel had said my behaviour was "outrageous and wrong." The only use of the word "outrageous" in Counsel's report was by Wilson, in relation to the email I sent to the board on 11 April.

Cullum was plain stupid. She argued that my "massive accusations" (which were facts) about tampering with evidence "against senior members of the collaboration" were "not fitting for a board member." She had the view that a board member should never criticise the CEO. If not, then why have a board of directors? She didn't know much about the issues - it was her first board meeting - and didn't speak during the first hour but made up for this later when she happily joined the witch-hunt.

The only time Counsel thought I might have done anything wrong, "I respectfully think," it was he who was wrong because he had not understood what centres are allowed to do. But Burton continued lying and said I was guilty of many violations and Koster also used an enormous amount of time on repeating the same falsehoods.

Burton and Howe blamed me for the time the board had spent on me, but Joerg said the blame should be put on Cochrane's CEO. Gerald agreed and mentioned a letter from senior Cochrane people asking that the Cochrane HPV vaccine review be retracted. He asked if these people would be expelled because they spoke out against Cochrane. Burton derailed the discussion, although Gerald persisted that this was a precedent, "more than Peter."

The co-chairs first focused on terminating my board membership, which was difficult, as I had been democratically elected. A smarter way of kicking me out was to declare I had breached Cochrane's Articles of Association, 5.2.1, which is about being "guilty of conduct which has had or is likely to have a serious adverse effect on the charity or bring the charity or any or all of the members or directors into disrepute," or 5.2.2, which is when one "has acted or has threatened to act in a manner which is contrary to the interests of the charity as a whole." These clauses were sufficiently elastic to be useful for expelling anyone Wilson didn't like. However, Counsel had not concluded that I had brought Cochrane into disrepute.

Burton argued that "if we actually say," I was guilty of having breached 5.2.1, the board could take my membership away, and then I would lose my place on the board because I was an elected member. Furthermore, I could no longer be the Director of the Nordic Cochrane Centre. It was not about proving that I had breached any rules, but merely saying "if I had."

Joerg did not accept Burton's vague argument about "the overall picture" but called for assessing the facts and being concrete about "where he breached whatever policy we have." Burton interrupted him, and Joerg said no more. Burton derailed this crucially important discussion when he sensed he was losing the debate. He also used Koster's trick about coming back to the really important issues later, which never happened. Joerg might have been exhausted when he caved in to this manipulation.

As a flower in a lava desert, there was a tiny intermezzo among all the defamation where the co-chairs considered an alternative exit where I left with dignity. Burton said I had a very senior reputation and suggested that I might agree to retire from the board and centre, "write the sort of letter that a Cabinet Minister writes when he resigns saying that, thank you very much, I've really enjoyed working with you … We write a reply that says, Peter, we're grateful for everything you've done over the last 25 years. You have great achievements, thank you very much for this."

Burton said he would be very happy with that, and Koster added that I would then retire as a senior statesman and my accomplishments would be celebrated.

David felt it wouldn't make that much difference because the scientific community, the *BMJ*, etc., would write about what had happened.

It was a grave mistake that the board never consulted me. Facing the alternative - being kicked out of Cochrane, likely losing my job, and leaving my life's work - I would have been highly motivated for finding other solutions. David drew the board's attention to Counsel's report, in which he mentioned arbitration: "I am really surprised that you used the words of the lawyers and the Counsel about these drastic measures when there's nothing close to those drastic measures mentioned by the Counsel."

Burton replied that Counsel had said in his report that arbitration would be disproportionate and extremely costly, and therefore not wise. This reasoning was totally flawed. Counsel did not suggest any drastic measures but to make the various policies and agreements clearer, to avoid disputes in future. Counsel felt I should not be disciplined because of the ambiguities. And what is expensive - in monetary terms and in lost reputation - is to skip mediation and escalate a conflict.

Burton did not even know if Cochrane would lose all the funding from the Danish Government to the centre and the three review groups based in Denmark by expelling me. He said that they had "spent a fortune on the lawyers." If his concerns had been cost and fairness, he would have chosen mediation.

Around 2 p.m., Burton and Koster discussed the situation in private, and Burton said: "We should pursue it to the end now."

This was an astounding revelation. Imagine a court case where the judges are too lazy to study the evidence put in front of them and ask others to do the work. It took me a very long time to prepare my report to Counsel, and even though I did not expect fairness, I thought that my careful rebuttal of the complaints would exonerate me, which Counsel actually did. I could not imagine that the board members wouldn't read my report, or, in case anyone read it, would ignore it completely. None of the board members mentioned any of my crucial arguments during the board meeting. Not one.

After a late lunch, the finale was approaching. Just to be sure, Burton said that my actions need not have had a serious adverse effect; simply the likelihood that they *might* have had that would be sufficient. With such criteria, anyone could be found guilty. That's like saying that driving is a criminal offence because you might run over someone. Later, I joked that the only difference to the Stalinist show trials was that I was not taken down in the cellar of the Lubjanka prison and shot in the back of the head.

Burton carried on with Wilson's Russian manoeuvres. He said that, internally, the reason for kicking me out would be that I had breached the code of conduct of trustees. This was false, but he added that this "is the motion that will be recorded in what are our confidential minutes that we keep for the 'board only' restricted time, and I can only imagine is, if the Charity Commission or anybody else asks to see them, they're not going to be public. The message that goes out is that he … um, well …" Burton was at a loss for words.

This was the eminent professor speaking who, according to Counsel, couldn't possibly do anything wrong and surely never tampered with any minutes, right?

And it got worse:

Koster: "He has made, um, you know, defamatory comments about the CEO, about the board members, I mean there's a litany of different things here as well."

Nancy: "So what, is that the policy?"

Burton: "So, so, so, so, can I just, just, just, just …"

Koster: "We don't have to put that on there."

Nancy: "Just because you don't like his behaviour, or whatever … we need to be clear when we say it to him, it was because of this and that."

Lamb: "Catherine, we can't have the Spokesperson Policy …"

Burton: "It just …"

Lamb: "It's just getting problematic."

Burton: "You just have to say that he breached the code of conduct of the trustees."

Cullum: "I think … there are people here, I'm guessing, that aren't sure that that is the case."

Nancy: "Yeah."

Joerg: "Yes."

Burton: "You don't think he just breached the code of conduct of trustees?"

Nancy: "It just says, it just says the policy … but what does it actually say?"

Howe: "That there are things that must promote leadership by example, adhere to charitable practice, avoid dominating contributions of others."

Nancy: "Should it be … code of conduct while he was a board member, because he was elected to the board, given what he did in the past, so the Cochrane Collaboration thought that whatever he did in the past was still OK, and that his reputation was still good."

David: "He was the highest, apparently the highest voted member …"

Nancy: "So, shouldn't it have to be what he did during the time that he was here?"

It is frightening that, after five hours of deliberations, the board still had no clear idea about why I should be expelled or whether I had broken any rules.

It is clear why Burton didn't want to be specific, as there was nothing to be specific about. Moreover, even if there *had* been concrete reasons, they would be kept secret. This violates fundamental Cochrane principles, and considering how grave the consequences would be - for me, my family, my PhD students, other close collaborators, and for Cochrane itself - it is remarkable that the process wasn't stopped.

As predicted by Gerald, things got out of hand, but Burton wouldn't listen, not even when two board members told him that lawyers are not useful for discussions of Cochrane issues.

Koster characterised my comments about the CEO and co-chairs as defamatory. As they were factual, they cannot be defamatory; they were for internal use only; and it was my duty as a board member to raise issues about mismanagement of a charity. That the board gave the CEO immunity is in itself mismanagement.

Joerg drew the board's attention to "how much we've been pushing that man in the last couple of years. I mean, if you push me that far, I'd lose my temper. Sorry. Mark lost his temper the other time and the Counsel excuses that. He grabbed me on the shoulder, I probably had a kind of haematoma, he shouted at me …"

David exclaimed: "Assault, assault," making a mockery of Marshall's ludicrous claim that I had assaulted Burton and of her suggestion that they should call the police.

Joerg: "He assaulted me, he called Peter a liar and we're excusing that!"

Koster, with the elegance of an elephant in a porcelain shop: "Let's put a motion."

Marshall suggested that I had breached the code of conduct and that I should resign as a trustee immediately. Joerg suggested I should just get a warning, and David, Gerald and Faba agreed.

Before the final vote, Burton upped his lies once again. He said I brought, then that I sought to bring, which is a very elastic concept, some people into disrepute including himself, Farquhar and Bero. He also said that, according to the lawyers, they didn't have to show "that there has actually been a serious adverse effect, just that there is likely to be."

The amount of destruction caused to other people and to Cochrane itself had no importance whatsoever for Wilson, Burton and Koster. History is full of narcissistic leaders that have not cared the slightest bit about the destruction they caused. Burton was not even moved when Joerg and Nancy explained that jobs could be at risk because the funding of the centres in France, Germany and Canada were linked to the Centre Director, nor when Joerg said that the board didn't care if the Nordic Cochrane Centre disappeared. Nancy added that the Danish government probably gave me lots of money because of who I was.

Burton's inner perpetuum mobile continued talking about my "behaviour," without specifying what was wrong with it. It was total Kafka. Burton launched the lie that Tovey was resigning partly because of me, supported by Koster, "Relentless, personal attack," and Marshall, "Bullying and hectoring."

The unfounded allegations and insinuations that I was the cause of virtually all problems in Cochrane escalated. It was almost like every speaker wanting to be even more wicked than the previous one. The co-chairs made it look like Tovey leaving because of me. Not so. He expressed a desire to leave already on 31 December 2017. And I had not attacked Tovey, or abused him, or bullied him. I always got along very well with Tovey and there was great mutual respect. The only thing I can possibly be criticised for is the comment I made in *BMJ* in 2015 related to the Maudsley debate (see page 315), but I was defending myself and my reputation against Tovey's unfounded public attack, which was not his own but ordered by Wilson.

By the end of the day, Burton claimed I had stressed a lot of staff, including Jo Antony, Julie Wood, Tovey, Wilson, and more junior people, and he added that I had criticised Tovey many times. This lie was so huge that it was in league with the insinuations that I should have harassed women sexually. In fact, people knew that Wilson's staff was leaving because of his brutal and poor management and I had treated him and his staff respectfully. Nancy said several times that the staff left not because of me, but because of "someone else." The

tyranny in Cochrane was so pervasive that she didn't even name Wilson. In the novels about Harry Potter, the You-Know-Who or He Who Must Not Be Named, is Lord Voldemort, the archenemy of Potter.

Burton argued that there should be zero tolerance for bad behaviour and Marshall that we should stand up for bullies. But if the board had truly believed in this, they should have sacked Wilson long ago. He was the one who bullied people and scared them, but the board did everything they could to protect him and make him as comfortable as possible. The recordings show that he was above criticism and had a God-like status, or should I rather say Godfather status? The board failed miserably in its responsibility to govern the CEO. It was captured by him. Zero tolerance for bad behaviour, which Burton said in his hate speech four days later, also means that Burton and Koster should have been kicked out of the board in disgrace. Cochrane was surely an upside-down absurd world at the top.

Marshall even had the audacity to suggest that I should send a letter of apology to Wilson. The victim of six years of harassment should apologise to the bully? What world is that?

Burton tried to put the blame on me when many young people did not like what they saw in Cochrane and therefore did not join the organisation. Nancy said they were disappointed because of the direction of Cochrane, not because of me. Burton then called me a "serial disruptor" with "very serious consequences" if I was not removed. That came close to being a serial killer, which is the only other term I am aware of where something is serial and harmful.

After more than five hours, Howe wanted to "sort out" the Spokesperson Policy, although Counsel had exonerated me and Burton no longer used this as an excuse for expelling me. What a mess.

Koster said I represented "the old regime" where "anyone should be free to express their opinions in any possible way" and that I would become "a dinosaur" fighting against any change and in need of a babysitter. I don't think dinosaurs had babysitters.

Cullum said I had breached the Articles of Association, then said that I had perhaps not breached them, but then "we have to act as if he is in breach."

Koster gave a highly misleading account of my meeting with her and Marshall during the Cochrane Colloquium in Seoul in October 2016. She said I felt "there was a big conspiracy" against me to push me out, which involved Wilson and three previous co-chairs, Bero, Grimshaw and Farquhar. "They were trying to force him out because he knew he had done some stuff, but he wanted to be a bit repentant about it, but he knew he might lose." This was a gigantic lie. I was only worried about Wilson, and I did not feel I had done anything wrong. I had never said, written or indicated that Bero, Grimshaw or Farquhar were trying to force me out. The problem was caused by one man, Wilson.

Koster also claimed that, "We spent hours with him talking him down." The truth is that I had asked Koster and Marshall for a meeting because Wilson had threatened to close my centre on several occasions. The meeting lasted only one hour, and they were very pleased with it and that I would run for the board, which they had suggested. I was very concrete and pointed out that Wilson was behaving unfairly to me and clearly wanted to oust me, just like he hunted down other influential people in Cochrane that had played a major role in making Cochrane a success. One man's bad behaviour cannot be a "conspiracy."

Koster told the board that she really felt we had a good conversation; that things were going great; and that, "I have always been optimistic about Peter, because he's a brilliant man …" If so, why must I then be ousted?

In an email from 20 February 2017, six months after Seoul, Koster wrote to me: “Just a quick note to congratulate you on your election to the Cochrane Governing Board! I'm so pleased that you decided to run for the board, especially after our discussion in Seoul. I think we will have a very effective board with a diversity of knowledge and experience ... I hope we have an opportunity to have a beer and chat.”

While I have not changed, Koster was a totally different person in 2018. She told the board that she “felt on some levels personally betrayed” and absolutely beside herself because I had publicly humiliated others (when I criticised the Cochrane HPV vaccine review). “Since I was appointed, I’ve done nothing but have to deal with Peter. And it has consumed days and weeks … to the detriment of my own job. If that is required … we aren’t going to find anyone who wants to do these kinds of things and this organisation is going to be run by ‘serial disruptors’ who do so in a way that is very objectionable and disrespectful and potentially defamatory.”

Wow. I almost became a serial killer again. And Koster lied bluntly again. She became external member of the Governing Board (called the Steering Group back then) in April 2016 and co-chair in September 2018, the month when I was expelled. And she was very pleased with me, at least as late as in February 2017, which her email shows, and likely much later. She did not have to “deal” with me before Wilson set his extermination plan in motion, which was in April 2018.

Marshall, the chief whip added: “Bullying.”

What an irony. Cochrane was run by a serial disruptor: Wilson, who *was* a killer because he killed Cochrane. His flair for destructing what others had patiently built up over two decades was second to none.

I couldn’t possibly have taken weeks of Koster’s time. And it was the board that had behaved in a disrespectful and defamatory way, not me. Marshall continued to make baseless allegations, the only purpose of which was defamation and character assassination.

Close to the end, David hit the nail on its head again. Cochrane leaders had told him that it was about the money, not about getting the science right: “What the Nordic Cochrane Centre does bothers a lot of very powerful people.”

Cullum said there had been major failings with the Cochrane review groups in Denmark that I hadn’t managed, but David noted that it was not my responsibility to manage the groups, and Joerg seconded him.

Burton noted that he visited me with Karla Soares-Weiser in Copenhagen and that I was very generous with my time. This was in June 2018, three months before I was expelled. He also said that “it was absolutely clear” that I had some control over the funding for the groups based in Copenhagen and had a leadership role in terms of overseeing them. This was not correct. I had no leadership role and no control over the amount of money they got. I solved Cochrane’s problem with two groups that did not function well, which involved major restructuring. Karla was very grateful for this, which would have been difficult or impossible for Cochrane headquarters to achieve without my help.

Lamb said that my expert report for the Dutch homicide trial was dynamite if it was out in the public arena, “stuff that would do Cochrane’s reputation no end of damage.” Burton called it an example of outrageous behaviour and said Loonen had been “perfectly right” when he complained about me to Wilson. He also talked about preventing damage by “rooting out the cause,” which sounded like extermination.

David explained that Loonen was accused of malpractice and is ill-repute. And Counsel did not consider it a problem that I had used my letterhead for my expert testimony:[1625] “My

conclusion is the same in relation to the expert report and the subsequent complaint against Professor Loonen in the Dutch proceedings. PG was there plainly not speaking about 'Cochrane-related issues.' I do not think it can be said that he was speaking officially on behalf of Cochrane." Moreover, my report was for internal use and was never made public. So, how could Lamb say it was dynamite when she had never seen it? I merely tried to help a mother get released on grounds of drug induced insanity. Is this really against Cochrane's interest, to try to obtain justice and to point out how dangerous psychiatric drugs are?

The co-chairs didn't care that Gerald had described the sanction they were about to impose on me as capital punishment, for a crime no one had defined, as in Kafka's novel, *The trial*. And, as noted, even though my centre was the biggest in the world, it didn't bother the co-chairs either that they didn't know if the funding for my centre and the three review groups and the Copenhagen Trial Unit would disappear if they expelled me, or whether around 50 people might lose their jobs because of this.

Joerg said that many people had broken the Articles of Association, including his boss, Gerd Antes, and that it gives room to people who don't like someone to punish them. Three weeks after my expulsion, Gerd wrote to me and others that he always used the Cochrane logo and letterhead to express personal opinions. When participating in hearings in the German parliament, he wrote about his expertise on Cochrane paper, as this was why he was invited, not because he was Gerd Antes. We should not apologise for our public appearances and wear a disclaimer that this was not Cochrane's view. If he were to tell members of parliament that, unfortunately, he was only presenting his personal opinion, it would be ridiculous.

The most important rule of justice is that if you want to sentence one person but not another, you must be able to explain the difference between the two cases. Burton was unable to do this. When challenged, he talked about the degree of the alleged violations, but the problem was that there were no violations.

Joerg challenged Burton to be very explicit on what basis he wanted to expel me, so that there would be a reference standard for the future. Faba repeated that it was not clear to her that I had acted or threatened to act in a manner, which is contrary to the interests of the charity. In fact, I had "done a very good contribution in favour of the charity."

For all interventions, we need to judge the balance between benefits and harms. This is what Cochrane does. But the co-chairs derailed any such discussion. I accept that some people find me difficult because of my non-British directness, but I am convinced that any objective assessment of my performance in Cochrane would conclude that the benefits by far outweigh the harms I caused. My critics should ask themselves: Why is this man so popular with patients? Isn't this what Cochrane should be all about, to benefit patients?

David asked for mediation, and the Charity Commission states:[1626] "If the trustees are in dispute, and cannot reach a decision, they could consider formal mediation or other alternative dispute resolution." A professionally acting board would have done that. The board should never have voted about my expulsion, but the co-chairs went for the kill Wilson had ordered. As Tom put it, the Cochrane lynch mob was out to get me.

The process got weirder and weirder. Burton prepared for the finale. He acknowledged that Counsel didn't censure me but added: "that is what Counsel sort of found," like when Koster said I had not broken the policy but the spirit of the policy. He didn't do anything wrong, but … which Schopenhauer called, "Postulate what has to be proven." It always works, if repeated often enough.

When Burton said: “We’re not talking about minor infractions here; we’re talking about really serious stuff here,” Nancy asked: “But what are we talking about?”

Burton lied when saying that all the allegations I had made about the behaviour of Wilson and himself had been shown to be wrong by Counsel, which, in Burton’s view meant that I was either misguided or malicious.

Amazingly, and very disappointing to me, all board members but David who abstained to vote found that I had breached the trustee code of conduct. Seven board members voted that I should resign from the board immediately. Only six of the 13 board members voted to expel me also from Cochrane: Burton, Koster, Marshall, Cullum, Lamb and Howe. David, Joerg, Gerald, Nancy and Faba refused to support this injustice with their vote and Clarkson abstained.

Burton was very disappointed and felt unhappy in many ways that it was a close call.

Cochrane came into deep trouble because it had employed Wilson as CEO but instead of realising this and supporting me, I became the scapegoat to be sacrificed, like countless others in human history. While we were still in Edinburgh, Tom published the article, *The crucifixion of Brother Peter*.[1627]

It is not nice to execute someone. Koster informed the board that it had “decided to cancel the dinner tonight. It’s been a very long day.” It would have been awkward, but I had decided to come, to meet with my friends on the board and to see how my executioners reacted when they saw the corpse was still breathing.

The same day, Burton and Koster informed me about my expulsion in an email. I had a week to appeal it. The next morning, I received another email from them, with the subject line: *STRICTLY PRIVATE & CONFIDENTIAL* and the message: “Please treat the email that we sent to you yesterday evening as strictly private and confidential.” What? I was supposed to keep my execution confidential. Had they gone mad?

That morning, Howe went past me in the hotel lobby where I sat waiting for a colleague. When she waved her hand and smiled, as if nothing had happened, I said, “Thank you for assassinating me. It is most kind of you.”

Still the same day, I informed various people, including those on the centre directors’ email list (but Wilson quickly deprived me of this easy way of contacting my colleagues), about what had happened and what it meant for Cochrane.[1628]

The next day, David, Joerg, Gerald and Nancy explained they resigned from the board because I had been expelled for "causing disrepute" to Cochrane:[1629] “It is our hope and deepest desire that this event will encourage all Cochrane members and the wider community to reflect upon where we currently find ourselves and give serious consideration to what we want for the future of Cochrane and its principles, objectives, and ethos.”

## Wilson’s gobbledygook at my last centre directors’ meeting

My last centre directors’ meeting took place three days after my expulsion. I had not planned to attend, but I met Joerg and Gerald in our hotel in the morning, which convinced me it could be interesting.

The meeting was scheduled to last 75 minutes and the agenda reflected Wilson’s inappropriate dominance. He had reduced the centre directors to spectators at the shows staged by himself and his leadership team. Only 25 minutes were allotted for directors to speak while Wilson’s team had 50 minutes.

The 47 directors in the room requested to drop several agenda items and to discuss my expulsion instead. Co-chair of the meeting, Swiss Centre Director Erik von Elm, lamented that there would not be the usual report from a centre director on the board, as they had all resigned - apart from Burton who cowardly didn't show up. Erik therefore asked Wilson to give a report.

I said I was still on the board because I had a week to appeal my expulsion, and that I would like to give a report.

I noted that there had been disagreements during several years between Wilson and me about the interpretation of the Spokesperson Policy; that I had tested it empirically; that Cochrane's hired lawyer was asked to go 15 years back in time: "You must find something on this guy because we don't like him, so we need to expel him;" and that he came up empty handed. I talked about Burton's amateur theatre (see page 371) and explained why four board members had resigned.

Wilson spoke after me. He was in deep trouble because he had plotted my expulsion and was now expected to explain the non-existing reason for it and because I was in the room. It was total gobbledygook. Like Burton, who doesn't have a moral compass either, he spoke about processes and was beating about the bush with management doublespeak. He was so incoherent that, if it had been a court trial, the judge would have asked him to come back when he was sober. I recorded his utterings:

"Um, so, it needs to be said, um, as CEO I was not in the whole, um, session that, that Peter was describing, I am only in the, as the CEO, at the service of the board, I was only in the business sections of the meeting, um, but precisely because, um, Peter has said that the process is ongoing, he has revealed something which the board has not in its statement last night, um, which, um, which is of course that he is the, um, individual whom the board has received complaints about, and, um, um, followed a process of investigating those complaints.

That process is still ongoing, as Peter, he is quite right, he said, he has, um, a period, um, um, to, to make further, um, further statements, um, to, um, um, to, to attempt to change the board's mind to rescind its position and therefore, um, um, the board, um, and I, um, can't say, um, um, and can't give a complete, um, um, picture, nor, nor should Peter in this, in this or other environment, nor should other board members and they are, they are aware of that, um.

Now obviously, since the board has, there is no question that this is an extraordinary situation, and there is no question that this is a Governing Board that is deeply split on its, um, assessment of, um, um of those complaints presented before it, um, so, um, all I would urge you to, to do is to, to please allow us to, um, to, to continue the process to, um, to its proper end, because, as, um, Peter said, um, when you start talking about lawyers and you start talking about, um, disputes, um, in the way meetings are conducted, appeals are conducted, and so on, then of course all of us are in a difficult situation.

So, I would just, I'm aware of the statements that Peter has made actually are, he sent it to you, and you are aware that the statements that the four board members who resigned, um, um, the statement that they have made, and I hope you are aware, too, that the statement that the board made, made last night, um, I hope, I perfectly understand that the messages from, from Joerg, um, made over night, um, that everything should be transparent, and there should be a big conversation about all of the circumstances that are currently, um, um, been gone through, um, but I would have to say, they can't be, um, um, you are not in possession of, um, of all the information, um, I am not in possession of all the infor-

mation, um, um, board members have been and, um, I would say, the process is continuing. Thank you."

A comedian couldn't have performed better than this, but it was a tragic sign of Cochrane's total moral collapse. It would have been better for Wilson if he had said nothing at all.

The statement the board had issued the evening before on the Cochrane website, which Wilson spoke about, was uninformative.[1630] I was not named but was "an individual."

Gerald explained that they resigned because they could not defend the board's decision and that the matter was far greater than me and had hurt Cochrane. Dutch Centre Director Lotty Hooft called for a discussion about whether the directors wanted to work in a scientific organisation where it was allowed to expel people with different scientific opinions and asked when such a discussion could come on the agenda.

Wilson replied that a discussion should not take place with only partial information. This essentially meant it would never happen because the board would continue to provide partial and misleading information. Wilson spoke again about processes, which he hid behind. He was very uncomfortable and continued speaking pure nonsense.[1631]

Gerd Antes complained that he heard the word "process" too often while nobody explained what it was, or how long it would take, and he said that people in a transparent organisation shouldn't be kept in the dark.

Empathy and listening are not among Wilson's strengths. He ignored Gerd's complaint and used the word "process" five times in his reply. Cochrane was processing itself to death.

French Cochrane Director Isabelle Boutron reminded people that the board's decision had already caused important damage, and that many French people were asking what was happening and were unsure about if they should support Cochrane, and if there would be any discussions within the organisation. She said they couldn't wait "for the process" to have a clear understanding of the situation.

In his reply, Wilson now talked about communication. This was typical of him. It was all about rules, processes and communication, also known as PR or spin, which were supposed to solve all problems. And Wilson's unintelligible, incoherent ravings continued, to such a degree that it was as if he had gone mad.[1632]

Erik did not understand the gravity of it all. Like Wilson, he alluded to processes and said that centre directors should not be pushed or feel obliged to position themselves, especially not from outside pressure. This was typical for Wilson's Cochrane. It no longer responded to the outside world but was inward looking. He added that if there were direct requests for what was happening, he suggested referring to the communications that had come out so that everybody could make up their own mind. This was ridiculous. The Governing Board's "communications" didn't tell people anything.

My deputy, Karsten Juhl Jørgensen, said that my expulsion had implications for many other people than just me, e.g. for our centre, and that this likely filled everyone in the room with immense sadness. "Peter is democratically elected and has views that are not always in accordance with the Cochrane leadership, so, expelling him of course challenges the democratic foundation of Cochrane, and I think that is very serious, too. It is not just a matter of scientific dispute … this whole process really questions whether this would still be an organisation that you would want to contribute to."

Despite the tyrant's presence, two centre directors had now openly wondered whether Cochrane was an organisation they would like to be in.

Singapore Cochrane Director Edwin Chan said that, earlier, when there was no formal membership of Cochrane, you were a member if you contributed, and therefore no one

could be expelled. He called for other solutions than expulsion, which went against the whole spirit of the Cochrane Collaboration.

Gerd called for a powerful political discussion within the Collaboration and noted, in response to Erik, that we didn't position ourselves. Others did, and they were making jokes about the Collaboration.

Cochrane Director Xavier Bonfill had attended a meeting for the Iberoamerican network the day before and said that people were shocked, frustrated, and angry about what had happened. They did not understand it or why Cochrane was not capable of dealing with differences in a more constructive way, especially at a colloquium whose motto was "Cochrane for all." He said that Cochrane representatives had the right to ask if warranties had been respected; that there were other bodies in the Collaboration that had the responsibility for assessing in a more neutral and objective way if someone deserved this kind of treatment; and that it was the first time a member had been expelled from the Collaboration in 25 years. Cochrane needed volunteers; it was a democratic, open, and transparent organisation; and it was the right of everyone to be respected in a constructive and fair way.

Xavier was also critical of the timing - that a decision was taken the day before the colloquium started - because the issue would contaminate and affect all discussions. He asked if it was planned and the outcome was expected, and he was disappointed that Burton wasn't present and gave an explanation because it was a very important question.

Wilson: "Just, just to say to Xavier, I have had nothing to do with this, what has been said, this has been a Governing Board process. So, that needs to be said. In relation to other business …"

Wilson intended to go back to familiar territory, his own agenda, but Gerald said it was an extremely important topic, four board members resigned, and we should not move on to the next agenda item but discuss the issues: "If you look at the media, what is going on, the damage is happening now. People will have to issue statements; the press is coming."

It was decided that the remaining 30 minutes should be used to continue the discussion.

I explained that, since it had been a semi-legal process, launched against me, I had asked for getting legal representation and for money to pay for it. I noted that I had donated more than 30 million crowns to Cochrane IT development, which Wilson took over against the wishes of my hospital and the Danish Government some years earlier, and that our centre did not get any economic compensation, although we had asked for that.

I said that I had not been allowed to defend myself throughout six hours where the board tried to find an excuse for expelling me, and that many things were said about me that weren't true.

Lotty supported me. She talked about "trusted evidence," the Cochrane motto, which we did not currently have, and democracy, and asked whether she was the only one questioning whether the voting was valid at all.

When Wilson talked about rules again, I said: "There are rules and there are moral imperatives. The remnants of the board could choose to resign, so that we could get a completely new board. That would morally be the correct thing to do considering what the board did to me ... that wasn't due process. Very, very far from due process. We made a huge error; we have harmed the Collaboration tremendously; we will resign. That would be the only decent thing to do for the remaining board members."

A centre director said that the centres could use this opportunity to make a statement about what centres believed Cochrane meant to them. Erik asked what the process would be and said that they didn't have a draft proposal. This caused people to protest and talk

over each other, and someone screamed: “It’s not that difficult!” I said: “Cochrane is drowning in processes, let’s work!”

I launched a simple proposal I suggested we voted on: “The centre directors support the motto of the colloquium, ‘Cochrane for all.’” This would send a good signal. No processes. We would support that Cochrane was inclusive, also for people who disputed the science.

Erik tried to explain that these were separate issues and talked about not dominating people. I said: “How can it be separate? That’s the motto for the whole colloquium. Come on now, Erik. So, Cochrane isn’t for all?”

Wilson: “The message was from the Governing Board. We are the servants of the Governing Board …”

Gerald showed his disdain for Wilson by calling his statement a platitude.

“Sorry Gerald but we are ... There will be a communication from the board … as regards the Twitter storm … participants in the discussion have gone public, that’s you guys - board members who lost the vote, have resigned and gone public. So, you have created the public outrage, so, to then use the public outrage to then say, Cochrane must do something out of the proper process is, to my mind, improper.”

Wilson had acted like a mafia boss, using Burton to do the hit job for him, but he now tried to put the blame on others for the calamity he had himself caused, which tactic Schopenhauer called “Turn the tables.” He was back in familiar territory and did not rave around any longer and did not stutter. But it didn’t work. Joerg was disappointed that none from the board came to discuss with the centre directors when the matter was so important.

Erik, Wilson’s useful idiot, had surely learned from him how to handle explosives by referring to formalities to avoid any discussion of burning issues. He replied to Joerg: “That was not on the agenda.”

So, the news that I had been expelled was not on the agenda! How deep could Cochrane sink? If there had been an earthquake that day, it would not have been on the agenda either, but people would need to make decisions. And my expulsion was kind of earthquake.

The news had spread like wild-fire, and the directors wanted to discuss this. The only thing lacking in this farce was for Wilson to say that the news needed to be carefully digested by his Knowledge Translation Department - his equivalent of Orwell’s Ministry for Truth or the Chinese Communist Party - before being communicated to the outside world.

## Burton’s hate speech at the Annual General Meeting

Many people were angry because they had not heard any good reason for expelling one of Cochrane’s most prominent researchers who had contributed a lot to the organisation and to helping patients, which is Cochrane’s *raison d´être*.

David quickly established a resistance movement. We tried to find out how we could overthrow the Cochrane government, but this wasn’t easy. There was nothing in the Articles of Association about what to do with a dysfunctional board. Our only possibility was to call for a vote of no confidence at the Annual General Meeting (AGM) and we collected signatures for a statement calling for the immediate dissolution of the Governing Board.

Wilson’s psychopathic traits knew no bounds. Karsten said Wilson had threatened to remove me as author of my Cochrane reviews if I wasn’t cooperative and conciliatory in my upcoming appeal to the board. However, he had no such authority. The academic rules ensure that no one can deprive others of their authorship.

Burton's psychopathic traits also had no limits. During the show trial, he noted I could say what I wanted "within the bounds of decency, defamation and hate speech." Only four days later, he delivered a formidable hate speech about me at the Annual General Meeting, which was recorded (starts after 36m20s),[1633] and published as a statement on the Cochrane website.[1634]

I have commented on this statement,[1635] which is highly defamatory and misleading. Cochrane headquarters ensured that all the 30,000 contributors to Cochrane saw it because they sent it out via group email lists, pasting the speech in the body of the email so that no one would miss it.

From left to right: Clarkson, Cullum, Faba, Howe, and Burton (in Edinburgh)

Before we came to this point on the agenda, we had been through the usual tributes to prominent people who had died since the last colloquium. One was Douglas Altman. When I co-founded Cochrane in 1993, it was with such giants as Altman, with whom I have published more papers than with anyone else, as already noted. But Burton was ice cold. It was all about getting the audience's sympathy for his "capital punishment," as Gerald called it. Burton did not acknowledge any of my achievements.

Adding insult to injury, the statement - Burton's hate speech - was undersigned "Cochrane Governing Board," but as I was still a board member and didn't know about the statement before Burton read it aloud, the authorship was false, which is a serious violation of publishing rules. I wrote to the board and asked who drafted the statement and who subsequently read and approved it. I also requested that the board insert an apology, explaining what had happened, which is always required for instances of false authorship. And I asked the board to consider apologising for its many untrue statements. I never got a reply, not even when I wrote to Wilson and Tovey and pointed out the misconduct. Cochrane leaders had stopped caring about ethics.

Burton said: "We wanted to behave fairly and with integrity, in a process that respected the privacy of an individual." It was none of this and by reading the statement aloud, the board did not respect my privacy.

"This is about the behaviour of one individual." Everyone knew it was me.

"There has been a lengthy investigation into repeated bad behaviour over many years." This is highly misleading. The investigation was carried out in a haste. Even worse, the text insinuated (why else mention it?) that the investigation found me guilty of something, which isn't true. Cochrane editor Jos Verbeek asked twice at the AGM what the alleged "bad behaviour" was about but did not get a meaningful reply.

"Four board members chose to resign and have actively disseminated an incomplete and misleading account of events. At the same time, others contributed to a public and media campaign of misinformation." These accusations were outrageous and wrong, and the board provided no evidence for them, or indeed, for anything else.

"To act in the best interests of Cochrane." This was hypocritical. If true, the board would not have expelled me but fired Wilson; Burton would not have given a hate speech; and the board would have resigned.

"We cannot tell you everything ... individuals have a right to privacy and confidentiality." When you don't have a case, you either say you can't talk, or you spread lies. The board did both.

"All our staff, and our members, have the right to do their work without harassment and personal attacks. We are living in a world where behaviours that cause pain and misery to people, are being 'called out'. This board wants to be clear that while we are trustees of this organisation, we will have a *'zero tolerance'* policy for repeated, seriously bad behaviour. There is a critical need for ALL organisations to look after their staff and members; once repeated, seriously bad behaviour had been recognised, doing nothing was NOT an option."

Burton used dramatic intonations and put undue emphasis on words such as "zero tolerance." The insinuations were clear. Several people thought I had sexually harassed women, committed serious crimes repeatedly, or had bullied Cochrane staff. None of this was true, and there was no support in Counsel's report or elsewhere for such allegations. In contrast, I gave many examples in my report to Counsel that I had been bullied, often in the most disrespectful way, by Cochrane's CEO and his staff.

"So, here are the facts as we are able to report them. We may be able to tell you more later, we may not. Time will tell." Then, Burton read aloud from a slide:

This Board decision is **not** about freedom of speech.
It is **not** about scientific debate.
It is **not** about tolerance of dissent.
It is **not** about someone being unable to criticize a Cochrane Review.

Four are still four lies, even when being denied in bold. And the strong language continued:

"It is about a long-term pattern of behaviour that we say is totally, and utterly, at variance with the principles and governance of the Cochrane Collaboration. This is about integrity, accountability and leadership."

Gerd Antes wrote to me and others that this statement was incredibly ignorant and arrogant. It suggested that many highly respected people were too stupid to have recognised my bad behaviour for many years. At the AGM, he jokingly said that he had been a witness of that bad behaviour for 25 years (without noticing it). Two weeks later, he stated that the board's conduct, in a deleterious way, showed that Cochrane departed from its objectives and undermined fundamental management principles such as transparency and integrity.[1636]

"In March this year, we received three complaints about an individual. These were not the first complaints that had ever been received. In fact, the earliest recorded goes back to 2003. Many have been dealt with over the years. Many disputes have arisen. Formal letters have been exchanged. Promises have been made. And broken. Some disputes have been resolved, some have not."

This was a masterpiece in manipulation and Burton forgot to say that Counsel had exonerated me. When scientists challenge the status quo with good science and face "complaints," it should be seen as a badge of honour showing that they have integrity and do not try to arrive at politically correct results. Considering Counsel's report, it was very misleading to say that I had broken promises. But the audience didn't know any of this.

"The individual then made serious allegations against one of the Senior Management Team and shared those with the Board. We seemed to be in an impossible situation."

The board knew this statement was misleading. I did not raise allegations but described facts in my email to the board, and Counsel did not find anything wrong with that.

"The report completely exonerated the member of the Senior Management Team but did not exonerate the other individual."

This was mendacious. I assume they relied on the confidential nature of Counsel's report to conceal this deception, but, as already noted, I made it available later on my website.

"The trustees reviewed the lawyer's report … and all the material related to the recently published paper ... looking across a broad range of behaviours."

This was also mendacious. The board did not consider all the material related to our criticism of the Cochrane HPV vaccine review, and Burton needed to hide what the "recently published paper" was about because he argued that my expulsion was *not* about my criticism of a Cochrane review. Burton did not say that he refused to send Wilson's exoneration of his own employee to the board, which would have stopped the show trial, and he did not say that the board failed miserably in its duties because they had not read the material sent to them.

Looking across a broad range of undefined behaviours is so vague that anyone can be expelled. People started worrying that they might be next in line to be expelled if they didn't follow Wilson's party line.

Burton carried on with his horrific manipulations. He showed a slide that said, "The independent review did not exonerate the individual." A legal review paid for by one of the sides in a dispute and offered incorrect, flawed and fraudulent information only from that side cannot be said to be independent. And the use of the phrase "did not exonerate" falsely insinuated that Counsel found me guilty of wrongdoing.

After Burton's hate speech, we expected we could ask questions. Not so. There was an intermezzo about financial issues before the question-and-answer session, which Koster chaired. The first question was about science. Already after the second question, Koster said there was no more time for questions. This was disgraceful. Previous AGMs had a lot of time for questions, and this is the only time in a year that the members can ask questions of the Governing Board. On top of this, a session that was to follow had been cancelled, so there was plenty of time before the Gala dinner close by. So, Koster lied again.

Under Wilson's dictatorship, dissent was not allowed, and no one could question the Great Leader about whether his victims had had a fair trial. However, the audience protested loudly and pressured Koster to allow more questions.

The defamatory claims about my behaviour were so shocking that they paralysed people in the audience. Neither Karsten, my deputy, nor my other chief physician, Klaus Munkholm,

rose to my defense although they had agreed to do this, and although I signaled to them that they should rise from their chairs. It was immensely disappointing, also considering what I had done for them and the research environment I had created. All of us loved going to work every day. I didn't know that Karsten had betrayed me. He was afraid of losing his job and had been seen in amicable conversations with two of the tyrants, Wilson and Bero.

Maryanne Demasi was familiar with these kinds of processes after having worked in academia, media and politics. She challenged the board members:

"There have been some very serious allegations made about this particular individual, of 'seriously bad behavior' without a fair opportunity for that person to contest these allegations and defend himself. So, is it possible you could expand on this and allow that individual to defend himself in an auditorium of his peers to avoid any allegation of defamation?"

Burton lied. He claimed there had been plenty of fair opportunity and added that "the board had a very large amount of information on which to make its decision." He forgot to say that he had planted some of this evidence himself.

Burton called for another question, but Maryanne interjected and talked about the lack of procedural fairness of the process, including that I was given five minutes to state a defense, before being asked to recuse myself from the room before deliberations occurred, and that I was not provided access or assistance to legal advice.

Burton refused to reply to Maryanne's information, which he called assertions. "But I can assure you, and I can assure everybody in this room, and I can look every single person in their eye in this room, we can all look you in the eye and say there has been a completely independent and fair, transparent process. The whole thing, the Cochrane Collaboration has lawyers to advise us, they have advised us every single step of the way and will continue to do so because the Collaboration needs to act legally at all times. It has done so, and will continue to do so but on the specifics you asked, 'no comment.'" Psychopaths speak this way. It was like when US President Richard Nixon said on TV: "I am not a crook."

I said that all these allegations about bad behaviour were false, and that the lawyer's report exonerated me from having broken the Spokesperson Policy:

"This will not be over, in this Annual General Meeting, you have just made it worse. I hoped that you would come to your senses. This is very bad for Cochrane, and it will be even worse in the future. It's a show trial completely from beginning to end; you took none of my comments into account. It didn't mean anything. The verdict was already dictated from the beginning and I'm sure it came from our CEO, so why don't we come with a vote of no confidence for the whole remnant of the board and get a new provisional board in three months and start all over again? Otherwise, Cochrane will suffer a lot more. I will survive, but I'm worried about Cochrane."

Burton chastised me saying that I made a serious allegation against the CEO.

I responded: "I will come back, probably with legal help, and there is also the Charity Commission. I have documented serious mismanagement at the top of the Cochrane Collaboration, and I think the Charity Commission would be interested in this, frankly."

I talked to many people after this. They were all in shock. This was not the Cochrane they so much treasured. Very, very far from it. What happened was so evil that no one would have thought it was real but must be a nightmare or a horror movie.

The hashtag for the Colloquium was #CochraneForAll. In the article, *Ugly scenes in the Cochrane Collaboration as Peter Gøtzsche is expelled*, Jon Brassey suggested the hashtag #CochraneForAllExceptPeterGøtzsche and said that if Cochrane is seen as just another large

ruthless commercial organisation, they may find their pool of volunteers evaporating rapidly.[1637]

Two days later, the UK Council for Evidence-based Psychiatry expressed what many felt:[1638]

"Prof Peter C. Gøtzsche is known throughout the medical world as a tireless advocate for research excellence, a fearless critic of scientific misconduct, and a powerful opponent of the corruption of research by industry interests. His meticulous integrity in demanding the highest standards from his colleagues has won him the admiration of patients, researchers, doctors, campaigners and advocacy groups worldwide. We believe it is deeply regrettable that members of the Governing Board should have voted (by a majority of only 6 to 5) to expel Peter, especially since no objective evidence has been provided to support the decision they have made."

Janus Bang talked to many people in Edinburgh and beyond, and he concluded that Wilson undermined everything he could: my person and motives, my professional skills and reputation, my scientific studies and books, my centre, my private economy, and my supporters (as he attacked the four board members who resigned in protest).

Janus drew a parallel between the actions of the Cochrane leadership and US President Donald Trump: You set an agenda that paralyses people by denying the facts; create your own facts; accuse your opponent with bizarre allegations without evidence; and dismiss any evidence that goes against you. The Cochrane leadership and Trump lied to an extent few people had seen before.

I had a week to appeal. On first thought, I did not want to appeal because my supporters on the board had resigned and those who voted to expel me would judge my appeal. This was the antithesis of justice and gives connotations to regimes we abhor.

I nevertheless appealed to show how unfair Cochrane "processes" are and to see how the board would react. I was also keen to avoid even more lies, e.g. that I accepted I had done wrong because I did not appeal.

Wilson and Burton calculated that they could "strangle me in the basement with no witnesses," as MEP Margrete Auken so colourfully phrased it, because the colloquium would be over before my appeal would be rejected. The board had expected me to say nothing about my expulsion during that week because I was still a board member. But I am not that stupid, nor am I that subservient. When you have been exposed to gross injustice, your right to self-defence overrides any bureaucratic rules.

In my appeal,[1639] I called for a group, external to Cochrane, to set up an independent committee of trusted people who had nothing to do with Cochrane, but who had experience in mediation, law, medical science and medical editing, to judge my case carefully, with no haste. Alternatively, the board should reinstitute my Cochrane membership, acknowledging the gross injustice and defamation I had been exposed to. I requested the opportunity to participate in any deliberations, also oral ones, like in a court case, and to contest any explicit reasons for my expulsion.

According to the Freedom of Information Act, I requested a copy of all recordings made at the 13 September board meeting, and the written minutes and drafts for these.

I asked for the evidence the board had used to verify that I had harmed the charity or brought it into disrepute, and whether the board found it acceptable that the explanations given about why I was expelled had the character of a moving target, as Burton gave new reasons at the AGM.

I noted that I had written in my report to Counsel that the 13 September board meeting was preliminary because I needed more documentation before I could provide a final report; Counsel asserted in his report that he had not had sufficient time to write it; and he had therefore outlined this plan: Counsel delivers his initial report in advance of the board meeting on 13 September; the board considers the report; Counsel responds to questions and finalises his report; and the board then considers and debates the final report.

I had therefore trusted that no decisions would be made at that meeting, and that the process would take some time. However, the board disregarded Counsel's advice, which contradicted Burton's numerous assertions that, "We followed the advice of the lawyers at all times."

I noted that the current Cochrane leadership tried to avoid challenging established dogma, although the basis for founding Cochrane 25 years ago was exactly that: to challenge established dogma.

I stated that the evidence I had provided disqualified Burton to judge my appeal and that the other board members were also disqualified, given that they arrived at a verdict based on flawed evidence and under the leadership of a chair who seemed to be very dictatorial and did his utmost to disgrace me and pervert the course of justice during the board meeting and at the AGM.

I explained at length why Counsel, in contrast to the board's view, had exonerated me and where his report was in error. I also commented on Wilson's exoneration of Lasserson who wrote the Cochrane editorial about the HPV vaccine review, and I concluded this meant Wilson could not criticise and discipline me based on the Spokesperson Policy.

I mentioned several important incidents from the board meeting the resigned members had told me about, including my strong suspicion that Burton had orchestrated the letters of complaint related to the HPV affair; that threats had been made that anyone who disputed the board's decision would be removed from the board; that Cochrane's CEO had threatened the board; that a board member had reminded the others that the CEO could sue them; and that a kind of lynch mood was created in the room, although people were aware that the meeting was being recorded.

On 24 September, I received an email from Lucie Binder informing me about a board meeting the next day about my appeal, which I could not participate in. As I was still a member of the board, I asked to see the call for the meeting, which Binder refused to give me, against the rules. I also complained that I would not be allowed to defend myself at all. I copied the two co-chairs of the board on my email but did not hear from them.

The next day, Burton informed me that my expulsion had been upheld in an email called STRICTLY PRIVATE & CONFIDENTIAL. I have documented that the reply I received from the board was full of lies.[1640]

The show trial was now completed, and the rules were broken till the very last minute.

## After my expulsion, Cochrane continued to lie about the issues and received complaints

How did Cochrane react after my expulsion? The way any business with a dishonest leadership would react. It hid behind confidentiality clauses and continued to defame me, misleading millions of people, including its own members, about what really happened that day in Edinburgh.

Cochrane went into damage control. It spent the next weeks justifying its actions, issuing mendacious and defamatory statements against me during carefully staged public events. This set off a chain reaction of protests by scientists and members of the public, many demanding that the decision be overturned.

Cochrane's actions were widely condemned in top journals, e.g. in *Science*, *Nature*, *Lancet* and *BMJ*.[1641] Many people lost their trust in Cochrane because of the gross injustice towards a person whose science and integrity they respected.

Nigel Hawkes wrote in the *BMJ* about our criticism of the Cochrane HPV vaccine review,[1642] and Michael Baum, Professor emeritus of surgery, University College London wrote in a comment to this: "I believe that Peter is a luminary of the Cochrane Collaboration and adds to the credibility of the organisation ... Without Professor Gøtzsche we might be minded to cease collaboration with Cochrane."

Jeanne Lenzer, independent journalist and *BMJ* associate editor, New York, wrote: "This is deeply, deeply disturbing. The scientific process advances through vigorous examination of conflicting evidence and claims. To silence one side undermines this process ... Cochrane's action in expelling Peter Gøtzsche is an ugly stain on Cochrane that will remain for many years to come. It reduces my trust ... Shame on Cochrane."

Maryanne Demasi published, *Cochrane - a sinking ship?,*[1643] where she noted that Jo Morrison, the Cochrane editor who published the HPV vaccine review, had accused my team of risking the lives of millions of women worldwide by affecting vaccine uptake rates.

One of the board members who resigned said: "The prestige of a scientific institution has to do with its ability to manage critical debates, not censor them."

In the article, *Is Peter Gøtzsche the boy who sees that the emperor has no clothes and says so?*, Richard Smith, previous *BMJ* editor, wrote: "I've known Peter for many years, and despite his capacity for speaking out in extravagant terms he's a gentle lovable man."[1644] He repeated the beginning of his foreword in my 2013 book about organised crime in the drug industry and said: "Most of us either cannot see that the emperor is naked or will not announce it when we see his nakedness, which is why we badly need people like Peter." The gentle lovable man was expelled because of "bad behaviour."

The Governing Board was heavily criticised in a second *BMJ* paper by Nigel Hawkes:[1645]

"A statement read to the Cochrane annual colloquium this week in Edinburgh by the organisation's co-chair, Martin Burton, did not make clear exactly what Gøtzsche did to warrant his expulsion. Burton referred to 'repeated bad behaviour over many years' but legal reasons and reasons of privacy, he said, prevented him from saying more ... Cochrane's lawyer, Thomas Grant, concluded that it did not make sense to go over old ground … advice ignored by the board, which in the statement read by Burton made the claim that Gøtzsche's bad behaviour was of a longstanding nature ... 'I am not sure it would be fair to censure PG,' Grant concluded. It is plain, however, that relations between Gøtzsche and Wilson had totally broken down. At a board meeting in Lisbon, Gøtzsche charges, Wilson lost his temper. 'He shouted, called me a liar, and said that I couldn't be trusted because I changed my views all the time.' His statement concludes by calling for the resignation of the board, which, he says, has caused 'tremendous harm to Cochrane.' The *BMJ* asked Cochrane to comment on Gøtzsche's claims and on the future status of the 17 Cochrane reviews he has published but was told that while the process was ongoing it was impossible to do so."

The last sentence is hilarious because the board has never been able to explain why I was expelled, simply because there was no reason for it. They tried, but all their attempts to do so were untruthful.

In response to one of Hawkes' articles, under the heading, *Cochrane's sinking ship and conflicts of interest*, the International Society of Drug Bulletins wrote that, already in 2013, they criticised Cochrane for allowing conflicted authors with the healthcare industry, and that its membership journals would not allow this any longer.[1646] Furthermore, also in contrast to Cochrane, none of the editors could have such conflicts. "Cochrane is damaging the trust and credibility doctors, pharmacists, scientists and patients have put in them."

On 27 September, journalist Bente Bundgaard, who saw what happened in Edinburgh, published the article, *What now, Cochrane?*, in our medical journal.[1647] She asked: "If Cochrane researchers are not particularly more independent than everyone else, if they engage in reviewing frivolous subjects, and if their reviews are not - anymore - considered qualitatively better than others, then what exactly is Cochrane's mission? If the collaboration does not find an adequate answer to that question, the network's special position is over. So, Cochrane's aura has not only faded. Then the star is completely extinguished."

On 13 September, *STAT and Retraction Watch* published an article I commented on later[1648] where Koster gave reasons for my expulsion. Presumably, she thought I would not dare publish Counsel's confidential report and that she would therefore not be held accountable. She miscalculated. Virtually everything she said in the interview was either mendacious or misleading, which was clear from Counsel's report that I had uploaded the day before.[1649]

Journalist Ivan Oransky published Koster's claims and did not bother to check them. She accused me of having repeatedly misused my centre's letterhead to espouse personal views but she back-pedaled from this falsehood on 3 October when she and Burton sent a letter to my private home address about the reasons for my expulsion (see below).

Koster talked nonsense when she said it is not a Cochrane view to ask a funder about deaths in a study, and she claimed that the decision to expel me was not based on my criticism of Cochrane's HPV vaccine review, which was also false.

She delivered a self-serving argument: "The vast majority of responses I've received have been very thankful that actions are being taken, and that this kind of behavior should not be permitted." Well, likely hundreds of thousands of people were angry, and those who were thankful might have bought into Burton's insinuations that I had sexually harassed people.

The co-chairs continued to lie profusely about me and to refuse defining what my so-called bad behaviour was about even though the process was over and it was no longer possible to say they couldn't comment because the process was ongoing.

On 1 October, Ryan Horath wrote:[1650]

"The 'seriously bad behaviour' is disagreeing with those who had the power to expel Gøtzsche and objecting to their behaviour. So, this appears to be the expulsion of a whistleblower arranged by those he accused of misconduct … In what world does it make sense to threaten to close an entire Cochrane centre because its director asked for information on how and why so many children died in a study? Who wants to be a part of an organisation that prioritises the letterhead used to ask questions over answers about dead children? … Dr. Gøtzsche's work makes him 'controversial.' The CEO of Cochrane is not a scientist. He comes from the business world. And in the business world, controversy is considered bad for the brand. And employees who rock the boat and do not fall in line with orders from above do not last long. Corporations are dictatorships, not democracies. The CEO brought a dictatorial mindset to Cochrane, and he believes Gøtzsche is bad for the 'brand.' Not being a scientist, he has no recognition that the work Gøtzsche does IS the brand. The ideal of science is not sitting by idly while science is perverted by moneyed interests. The ideal is

someone who thoroughly vets the science being produced and is willing to challenge corruption at great personal risk. So, in the CEO's mind, any appearance of the Cochrane name next to Dr. Gøtzsche is bad for the brand."

On 3 October, I received the official reasons for my expulsion in a posted letter where Burton and Koster repeated their lies. They claimed I had breached the Collaboration Agreement, which wasn't true (Counsel had misunderstood this), and had "broken the spirit of the Spokesperson Policy if not the letter." This is the first and only time the co-chairs admitted that I had *not* broken the policy.

Their letter had no heading. It started with this text, in bold: "**Addressee Only. Strictly Private & Confidential. NOT FOR PUBLICATION OR DISSEMINATION**."

So, even the verdict was supposed to be secret. This was full-blown Stalinism in Cochrane. I uploaded the letter on my website[1651] and tweeted their hilarious message, with a link to the letter: "Cochrane Governing Board: Gøtzsche had 'broken the spirit of the Spokesperson Policy if not the letter.' Has Cochrane become a religion? Will we see an Orwellian Cochrane thought police soon with CEO Mark Wilson as supreme judge?"

In their letter to me, Burton and Koster included events going back to 2003 although Counsel had found this inappropriate, and they claimed that I had undermined Cochrane's reputation and the functioning and work of the board, the Central Executive Team and the organisation as a whole. A huge mouthful, and a huge lie.

Burton and Koster admitted that our criticism of the HPV vaccine review was a reason for expelling me, although they had fiercely denied this on all previous occasions: "A new issue has arisen even since the Independent Review was commenced (in relation to the HPV paper)." They even criticised my conduct *after* I was expelled, but it was my right to defend myself against the serious defamation and multiple lies they continued spreading.

On 3 October, the Cochrane centre directors in Spain and Latin America called for an independent investigation of the process around my expulsion:[1652]

"We have doubts that the process has been sufficiently appropriate and coherent with the principles of Cochrane … Any entity (e.g. a political party, a trade union, a religious organisation, the university) have well-established internal mechanisms that guarantee an objective analysis of the accusations and defenses, as well as the right to appeal with the necessary guarantees to a neutral group or commission different from the one involved in the conflict. These mechanisms and the associated processes should be transparent and auditable … Expelling a member from an organisation can never become … a summary process that lacks the necessary transparency, and this is … how we and many other people in our organisation and outside of it have perceived the resolution of this conflict … We do not want Cochrane to become an organisation that passively accepts the decisions made by its leaders … without enough collective mechanisms for discussion, contrast and control … We propose:

1 That the Governing Board calls immediate elections to renew the set of vacant positions in the Board, and thus give the opportunity to incorporate other perspectives and sensitivities to the government of the organisation, and particularly, to the management of this issue.

2 That the new board appoints an *ad-hoc* commission, without the participation of any person who has been directly involved in the conflict, so that it independently reviews all the actions related to this conflict and establishes the possible responsibilities that will then be assumed consequently.

3 That the report of the mentioned commission is known and discussed by the different Cochrane members and entities, so that the conclusions derived from this discussion can be incorporated into the regulations and processes of the organisation: guarantees and rules to objectively assess possible faults and respect the presumption of innocence, the right to defense, the equality of opportunities, and the impartiality of those who qualify the alleged faults and apply proportional sanctions to the infractions, if any.

We would appreciate that you consider it and share it with as many people as you feel appropriate."

It is noteworthy that, ultimately, all the 31 Cochrane Directors in Latin America and Spain signed this letter. During his hate speech, Burton said that "We know bad behaviour when we see it." In Latin America, they know a dictatorship when they see it. Desmond Tutu, a black Archbishop and Nobel Peace Prize Winner from South Africa, said: "If you are neutral in situations of injustice, you have chosen the side of the oppressor."

The Governing Board used five pages to pave the way to its conclusion:[1653] "We believe it is not in the charity's best interests to undertake another independent review."

The translation of this is: "We believe it is not in the board's best interests to undertake another independent review because we would not survive it."

On 4 October, Cochrane's CEO and Governing Board held three webinars for Cochrane members where they lied profusely when they tried to explain why I had been expelled.[1654]

Although the Spanish speaking centre directors had encouraged the Cochrane leaders to share their message "with as many people as you feel appropriate," their statement was not even mentioned at the webinars. They were accompanied by highly untruthful slides:[1655]

"A consistent placing of his own interests above those of Cochrane." The board propagated this statement in bad faith because I explained in my report to Counsel that it is a false dichotomy. The fact that I was a respected researcher who published research that is useful for patients played a major role for my success with getting Danish Cochrane activities on the government's budget.

"Multiple warnings were given & conversations took place in concerted attempts to deal constructively with the issues." Publicly disagreeing with someone's science is hardly a basis for a complaint about my "behaviour." Wilson gave me multiple warnings about my alleged breaches of his Spokesperson Policy, but Counsel found I never breached this policy.

"A repeated representation of personal views as those of Cochrane despite requests and promises not to do so." This was a gigantic lie. No one had ever honestly confused my views with those of Cochrane as an organisation, and the board had not explained why it ignored its own legal report that exonerated me.

"Multiple complaints to Cochrane over a number of years." That the board mentioned this after all my explanations and Counsel's report, illustrated Cochrane's moral collapse.

"Serious, defamatory and outrageous allegations against Cochrane colleagues - and publicly." These were not allegations or defamation, but facts, and I did not go public before the board had expelled me in a show trial and continued lying about me.

"As a member of the Governing Board, a serious breach of the Trustees' Code of Conduct." At no point had Cochrane or Counsel demonstrated to me that I had breached this Code.

"Cochrane welcomes and supports academic criticism as part of our culture." As I have documented, this is clearly *not* the case.

"As a trustee and Centre Director, Professor Gøtzsche had a special duty of care to act in the best interests of the organisation when making criticisms of Cochrane Reviews." This was diffi-

cult to reconcile. Our criticisms were scientifically well founded and whether one is allowed to criticise should have nothing to do with the number of Cochrane stripes one has on the shoulder. The board also contradicted its claim about welcoming academic criticism.

"With his critique of the HPV vaccine review, published in *BMJ Evidence-Based Medicine* without prior warning, he chose not to act in Cochrane's best interests. This is an example of bad behaviour, but it is not the reason for termination of membership." The board knew perfectly well that we warned Cochrane multiple times, and that I could not warn about our publication because I was on holiday. Moreover, our criticism of the Cochrane HPV vaccine review *did* play an important role for my expulsion.

"The Board's decision had nothing to do with conflicts of interest or Cochrane's determination to have robust COI policies and apply them properly." Burton had a huge conflict of interest when making a decision about my fate.

"The Board rejects any allegations of closer links to commercial organizations that would threaten Cochrane's independence and credibility. There is no evidence for this because it is not true." Blanket denial of something doesn't mean it isn't true. If there are links between Cochrane leaders and the drug industry, this is not something people usually reveal. Their actions suggested there was some dependence, which many people suspected.

"Professor Gøtzsche's behaviour would not be allowed in any of the organisations by whom we are employed." My behaviour was welcomed in the organisations that employed me, the Copenhagen Hospital Corporation and the University of Copenhagen, which, in contrast to Cochrane, do not accept scientific censorship. My behaviour was appreciated to such an extent that the Danish Minister of Health, Ellen Trane Nørby, told me at a meeting I had with her and the Directors of the Board of Health and of the Danish Drug Agency on 14 August 2018 that she appreciated that I challenged dogma. Cochrane should have been proud of having a person like me in the organisation. My priority was to be a champion for those in the community who didn't have a voice. This was much appreciated, particularly by psychiatric patients, and strongly recommended by Cochrane.

"Clarifying and enforcing expected levels of behaviour by Cochrane members - particularly its leaders - is critical to building a culture of trust, openness, respect and professionalism." The board did not clarify anything. They lied about the issues, totally lost the trust of Cochrane members, and were disrespectful and unprofessional.

"The Board followed due process during its investigation." This is as far from the truth as it gets, and the immediate resignation of four board members in protest demonstrated this.

"It also maintained duty of care to Professor Gøtzsche, even when he broke confidentiality and made defamatory statements against named individuals." As already noted, it was only *after* my expulsion on 13 September and *after* the board had disseminated outrageous lies and defamatory statements about me on 17 September that I made public statements, which were not defamatory. Moreover, there was a public interest in knowing about the issues that overrode any concerns about confidentiality.

"Cochrane's Central team is in contact with the Nordic Cochrane Centre's host institution and major funder to protect future support to the Centre and its employees; and to the three review groups also supported by the grant." This demonstrated the extent of Wilson's spite. He did not know if the funding I had obtained would disappear if I was expelled.

"Any group that uses Cochrane's name and logo must be accountable to Cochrane, follow Cochrane policies and practices, and act at all times in the best interests of the organisation and the benefit of the public. We will protect and defend Cochrane's organisational integrity fiercely."

A commentator wrote that these slides gave the impression that a main goal of the webinar was to discipline all the members of Cochrane.

In their verbal introduction to the webinar, the board gave as reasons for my expulsion that I had used my Centre's letterhead for expert testimony in a homicide trial, and that I had criticised Cochrane editors in 2015 in relation to the Maudsley debate. This was also mendacious. Counsel exonerated me in both cases.[1656]

The board noted that Cochrane didn't endorse my views. Which views? The board had not seen my expert report to the Dutch court, but was blindly making a statement, based on no information, just false assumptions. Furthermore, there were no views to be endorsed by Cochrane because it was not called to present expert testimony in court.

Gerald Gartlehner wrote to the other three resigned board members and to Tom, Maryanne, Karsten and me that, "Expelling a member is a very drastic action, and some people think that a criminal offense must be the reason for it."

Many researchers wrote similar things to me. The overwhelming impression was that all the secrecy was about protecting the privacy of the "victims" who were abused by my "bad behaviour." But I was the only victim.

One wrote: "I saw this as Martin's clever way of intimidating people into not supporting you - you don't want to support someone who has committed sexual harassment or something similar. Martin is a scary person."

Another wrote: "I thought already at the AGM that Burton's slide and speech were very explicit in their insinuation. When you read the whole paragraph, the #metoo insinuation is bent in neon."

Burton had made some people believe I had sexually abused women, even though they could not reconcile this with their knowledge of me. The defamatory insinuations were so horrible that the board sheepishly needed to state at the webinar that there were "NO allegations of sexual or physical misconduct, or any other criminal activity."[1657]

Two weeks before the webinar, Michael Baum from one of America's leading litigation firms, Baum & Hedlund in Los Angeles, wrote to a colleague of mine: "Do you have some intel into what Cochrane thinks Peter's bad behaviour was? Was in the process of including him and Tom Jefferson to be experts for Gardasil [an HPV vaccine] cases, but then all this crud flared up."

My colleague replied: "There is no serious bad behaviour - it's just a case of PG not singing from the same hymn sheet as the CEO of Cochrane who seems to be widely regarded as an anal asshole."

Michael: "So, no skeleton or sex/finance/corruption type stuff is lurking under the accusation of 'bad behaviour'?"

"It will leave a lot of people thinking Peter is a Harvey Weinstein. I think you could make a good case that there are lots of people - media, lawyers, professional organisations - who will simply remove Peter from their lists of people to consider for media, legal, clinical or research work on the basis of this slur. If they don't have someone to check with - like me in this case - they will just erase Peter's name on a risk management basis."

I am very grateful for the help I got, as Michael hired me as an expert for his lawsuit against Merck (see page 289).

A breast cancer patient, a long-time contributor to Cochrane, wrote to Cochrane headquarters that it sounded as if I had raped somebody.

On 4 October, the German Network for Evidence-based Medicine wrote to Wilson and Tovey that they were deeply concerned about what had happened.[1658] They did not understand why Cochrane had expelled "one of the most respected scientists and Cochrane founders ... We highly esteem the contribution of Peter C. Gøtzsche to the development of Cochrane and his support for our objectives to implement evidence-based medicine. Members of our network have voted for Peter C. Gøtzsche to become a leading member of the board because he is considered a person who is known for free speech and a strong character, for courage and his merits to a non-corruptible medicine. We do not understand how a minority of the board members can now be authorized to expel him ... Gøtzsche is one of the key players in a trustful future development of Cochrane … an organisation that lives from transparency. We miss this transparency and are deeply concerned about the democratic basis of this decision. We strongly recommend rethinking the decision and especially to transparently unveil all arguments which have guided the Governing Board's decision."

In their reply, the co-chairs repeated many of their falsehoods:[1659]

"Your letter contains a number of inaccuracies. It also draws conclusions on the basis of limited, biased evidence. Given your network's position in promoting the teaching and practice of evidence-based medicine we hope that, moving forward, you will consider the entire body of evidence pertaining to this matter."

There are no inaccuracies in the Network's letter, and it was the board that had disseminated incomplete and biased information. The board had censored the information they did not want anyone to see, but the Network had access to unbiased information because I had published it on my website.

"It appears that you condone the behaviour of Professor Peter Gøtzsche. We respectfully suggest that the behaviours he demonstrated both before 13th September 2018, when our Board first considered them, and especially subsequently (he has continued to disseminate shockingly defamatory materials) are not behaviours that would be found acceptable to the Universitätsklinikum Hamburg-Eppendorf, Universität Witten, Universität Hamburg, Martin Luther University, or other esteemed institutions. We should like to understand why then would they be acceptable to the EBM Netzwerk? … We are disappointed if your organisation, and those who fund you, believe that high esteem is more important than respectful, collaborative behaviour that clearly serves the best interests of Cochrane."

The co-chairs' arrogance, disdain, and hubris were second to none. There had been absolutely no "respectful, collaborative behaviour that clearly serves the best interests of Cochrane" on the part of Cochrane's CEO, the co-chairs and the remaining four members of the board.

On 30 October, the Network sent an open letter to Wilson:[1660]

"We are still or even more disappointed because the response does not contain any facts but keeps repeating the nebulous intimations regarding Peter Gøtzsche's 'behaviour' without presenting any evidence. This does not go along well with the quite impertinent incrimination of the German Network of Evidence-based Medicine … Ms. Koster and Mr. Burton accuse us of being inaccurate and drawing conclusions on the basis of limited, biased evidence. From our point of view, it is quite evident that the governing board is not presenting any evidence for its accusations but keeps reiterating untransparent and incomprehensible statements which endanger the trustworthiness of Cochrane and damage the reputation of the organisation. Once more, the spirit of Cochrane and its excellent standing require open communication and disclosure of the reasons why Peter Gøtzsche has been expelled from the Cochrane Governing Board, and furthermore why the other board members have not

yet resigned to open up the opportunity for new elections and strengthen the democratic basis of Cochrane. We completely miss the spirit of Cochrane in the handling of this affair. We fear that Cochrane's reputation is at risk of severe damage."

On 5 October, psychiatrist David Healy compared Cochrane to a cult,[1661] "whose leadership dictate what can and cannot be said. A cult, who in cutting off one of their only colourful figures, will be viewed as a bunch of grey men ... A cult whose value to science has plummeted to rock bottom."

He wondered how Cochrane can justify tolerating 25 years' worth of reviews based on ghostwritten articles and no scrutiny of trial data due to lack of access: "Surely, this has been as deep a betrayal of the core Cochrane mission as it is possible to imagine."

In his article, *How Cochrane is doing pharma a good turn*,[1662] Tom Jefferson shared Healy's concerns. Cochrane was willing to expel from its ranks a vocal industry critic despite the predictable and sustained backlash, and the organisation promoted a false sense of plurality when in fact the information released from Cochrane was now tightly controlled.

This is how industry operates. At present, Cochrane was performing useful functions for industry by creating a roadmap for the publication of commercial trials and then magnifying the effects of bias by including those trials too readily in its reviews.

Cochrane's failure to officially and actively push for open access to regulatory data and their inclusion in its reviews, or to address in a coherent, decisive way the underreporting of harms, aligned it with the aims of industry.

Trustees are obliged to point out if there is mismanagement in a charity and to complain to the Charity Commission when the issues are serious, which I did. The major issues were tampering with evidence; serious mismanagement; numerous violations of rules for charities and for Cochrane; lack of a collaborative, democratic, transparent, and accountable leadership; management by fear and bullying; an almost total lack of due processes, in stark contrast to other organisations; fierce resistance from the CEO towards introducing due processes; favouritism (other rules apply to CEO staff than to Cochrane collaborators); serious flaws and conflicts of interest in the process against me; scientific censorship although Cochrane is a scientific organisation; repeated, very harmful actions by Cochrane's CEO favouring industry and guild interests; and scientific misconduct in terms of false authorship.[1663]

I explained that when the scientific integrity of Cochrane is undermined, it impacts people broadly across the world and that it would be a major disaster for public health if the Charity Commission did not act swiftly and replaced the current leadership.

I was told that "there may be issues for the Commission to further assess," but unfortunately, the Commission is understaffed and decides itself which cases it will take up. I sent two reminders but got no reply.

## David Hammerstein's brilliant analysis of the show trial and Cochrane's collapse

On 8 October 2018, David published a brilliant analysis of the crisis on the *No Gracias* website,[1664] and here is a summary.

The crisis is about credibility. The focus on one individual´s behaviour is being used to avoid a serious debate on the future strategy and policies of the organisation. What has

moved the Cochrane leadership to take the exceptional decision to expel Peter Gøtzsche are his very visible actions in the fields of science, policy and medical ethics. The deliberate confusion of affiliation with representation has been used by the Cochrane leadership to attack and try to erode Peter's prestige related to his scientific and policy positions.

The paradigm held by the CEO deems that the preservation of a unified "brand" and a more centralised and authoritarian "corporate image" is of the utmost importance for the financial growth and stability of the Cochrane central office. The scientific, financial and policy independence of Cochrane centres outside of the UK could pose a threat to the consolidation of this common "brand". The executive team and the Governing Board presidency are openly reticent of contact with most public health NGOs and against Cochrane leaders taking clear public positions on transparency, open data, open science or medical innovation policies.

The big winner in this conflict has been the pharmaceutical industry, having succeeded in weakening the voice of one of its greatest critics and having consolidated a Cochrane leadership closer to industrial interests with fewer audible critical voices.

The Cochrane leadership has often shown disdain and impatience with any criticism of their work or proposals. What is especially grievous is that the Governing Board does not govern. It seems to be considered by the central executive team to be a mere rubber-stamp for their decisions. Only the two co-chairs of the Governing Board seem to have some fluid input into the decision-making process. They have never had a public word of discrepancy with anything presented to the board by the CEO.

Another example of this top-down control obsession of the Cochrane leadership is the "webinar" organised last week to "explain" the current crisis sparked by the expulsion of Peter. No convincing evidence was provided. All the microphones of the participants were muted. They were not allowed to speak, only to listen passively, and even their written questions sent to the CEO and the co-chairs were "re-interpreted" and formulated in different terms.

The whole process against Peter has been anti-democratic and none of the basic tenets of due process, fairness and transparency have been upheld. There has been no attempt at seeking outside neutral arbitration nor the use of techniques of conflict resolution with the aim of reaching a friendly agreement.

No time has been given to establish an independent committee of conflict made up of people from outside of Cochrane´s main institutions. Every step of democratic guarantees that is common in most large organisations has been ignored in this case with the objective of the rapid exclusion and tarnishing of Peter.

Peter has had no chance to defend himself in person before the board. He was expelled without even knowing what he was accused of, aside from the generic accusation of causing "disrepute" to Cochrane. The only accusation that had been made clearly, that he had violated the Spokesperson Policy, was not at all confirmed by the so-called independent Counsel.

Counsel did not make any recommendations for disciplinary action against Peter despite this being requested from the Cochrane leadership. The ambiguous phrase used publicly by the Cochrane leadership that the open-ended counsel report "did not exonerate" falsely insinuated that Peter was found guilty of wrongdoing on the part of the Counsel, but that did not happen. It is disgraceful that the Cochrane leadership has used such personal defamation tactics without any proof nor transparency.

What is totally unacceptable and probably illegal is that dark and ominous insinuations have been made about Peter, backed up with absolutely no evidence. Concerning his personal "behaviour," the Cochrane leadership has publicly and privately used the language of the "me-too" movement and "zero-tolerance" of sexual harassment and abuse.

The exclusion of Peter and the resignation of another four members of the board was a well-planned, predetermined operation for the elimination of all the critical voices from the Governing Board.

Shortly before the Governing Board vote that expelled Peter, one of the six members of the board that voted in favour of the expulsion stated that all the members of the Board were obliged to publicly defend the decision and not reveal the details of the close vote that was about to take place. What was also sought by the Cochrane leadership was a concealment of what had happened in the process, debate and vote.

At the Governing Board meeting in September 2017, Peter proposed a text, with the support of a number of other members of the Board, to substantially strengthen Cochrane´s conflict of interest policy, which today allows up to half of the authors of reviews to have conflicts of interests with the company that makes the product they are evaluating. This proposal was met with considerable resistance and outright discomfort from the Cochrane leadership; one of the Governing Board leaders even said that "without conflicted reviewers we´ll find no-one to do our reviews".

Over the next year, no progress was made on this conflict-of-interest proposal and a long, torturous bureaucratic procedure was suggested by the co-chairs with the intention of burying the whole issue.

It is no coincidence that Peter's expulsion took place when he had been insisting for over a year on a new, much stricter conflict of interest policy for Cochrane.

Over the past year, the CEO has insisted that they "are not ready" for taking public positions, that it is not a present priority, and he expressed in a written reply the need to plan advocacy carefully based on the "products" (systematic reviews) Cochrane develops. When one top member of the Cochrane team was asked about Cochrane´s relationship with the major public health NGOs that often present proposals for access to medicines and new open innovation models before the World Health Organization, he/she said that these organisations held viewpoints "too radical" for Cochrane.

What is evident is that Cochrane has not considered it important to influence public policy in areas extremely relevant and necessary for the production of "better evidence." As John Ioannidis has said, "evidence-based medicine" is misused and abused by eminence-based experts and conflicted stakeholders who want to support their views and their products, without caring much about the integrity, transparency, and unbiasedness of science. Some observers feel that many Cochrane reviews are being misused and abused in this very manner by the pharmaceutical industry. Especially criticised is the production of many Cochrane reviews based on journal articles without attention given to much of the clinical data which is often either hidden, censored or manipulated by the industry sponsors of the trials.

The present Cochrane leadership has sometimes chosen to ignore overt industry manipulation of clinical evidence and has occasionally even fallen in the trap of serving as "an industry advertisement tool" with a shiny Cochrane stamp on it that lends this publicity "independent" credibility.

Peter and others in Cochrane have defended the idea that evidence generated by companies with a vested financial interest in the marketing of the "reliability" of that evidence is

a great problem for medical researchers and the carrying out of systematic reviews. Most of the Cochrane leadership thinks and acts otherwise in the way it treats the evidence usually used as the "raw material" for systematic reviews. If that is added to the fact of a weak conflict of interest policy that allows up to half of reviewers to have conflicts of interest, Cochrane has a growing credibility problem.

## Cochrane editor Jos Verbeek establishes a resistance movement

US President Lyndon B Johnson said about J Edgar Hoover, head of the FBI, that it was better to have him inside the tent pissing out, than outside pissing in. I was no longer in the tent, and the Cochrane leaders continued pissing on their own people. Nothing was done. The Great Leader had obtained what he wanted.

On 15 October, Jos Verbeek, editor of the Cochrane Work group, called for action. Today, the links[1665] I provided in my second book about Cochrane's collapse to the documents Verbeek uploaded lead to these messages: "Access denied. You are not authorized to access this page" and "No link can be established to this website."

Wilson's destroyed not only Cochrane but also Cochrane's history, which he learned in Russia. School children in Russia do not learn about Stalin's mass murders, and those in China do not learn about Mao's mass murders.

Jos wrote on the Work group's website: "In all their statements the Governing Board has performed a methodical character assassination of Peter Gøtzsche by systematically classifying him as a person with very bad behaviour. I think this is inappropriate and the reasons for expulsion should be clearly articulated, so that we can all understand what this is about … The result of the process is that we are further away than ever from a climate in Cochrane where we can have constructive discussions on what we want Cochrane to be and where we want to go. The 'zero tolerance for bad behaviour' … has further increased the unsafe climate that characterises Cochrane.

You better not speak out because it might have consequences … all communication in Cochrane is top-down and there is no forum for discussion between members."

On 1 November, Jos launched the website, *Cochrane members for change*, where he noted that the lack of transparency and trust is detrimental to Cochrane. He listed what he would like to change: Create a culture of open discussion; refocus on the heart of Cochrane; increase the involvement of Cochrane members; and find a better business model for Cochrane.

In just three weeks, 620 people including many Cochrane directors and review group editors signed the petition. This was remarkable considering that those who signed were identifiable by their names and email addresses. Jos wrote to me that "the Central Executive Team is reading and recording this. Within Cochrane you have to be brave to sign a petition like this."

Jos communicated his petition via email to people he knew and via Twitter. When Gerd Antes tried to send an invitation to sign the petition via the centre directors' email list, it never came through. It was censored by Wilson's office, and the Cochrane Empire hit back in other ways. Former co-chair Lisa Bero and deputy CEO David Tovey found the petition destructive, and Lisa said it was "demoralizing to think that since 1996 I have devoted a large part of my effort to Cochrane and this is denigrated and dismissed. I can see why many within Cochrane have been demoralized by your effort. I think you should take the petition down."

Tovey wrote: "Highly inflammatory and inappropriate comments in relation to the removal of Peter Gøtzsche's Cochrane membership and also the upcoming election ... this is an unprofessional way to use a Cochrane sponsored website that is open to anyone. It is very disappointing

to see two people in leadership roles within our community insulting the Cochrane Governing Board and therefore publicly criticising three highly respected co-ordinating editors. I do not wish to see this escalate, so please remove this content immediately."

Also in the mob, you don't criticise your family – "our community" - in public. The Cochrane Club is untouchable and above reproach.

Jos responded that he asked several persons to read the texts before publishing them to prevent inappropriate content. He repeated that he was very critical of the process that led to my expulsion:

"One of my concerns is that 'a zero tolerance for bad behaviour' will be turned into a 'zero tolerance for dissident opinions.' Your message certainly increases this fear." He told Tovey he had a duty to inform his authors and editors about what was happening in Cochrane, and that they would soon leave if he did not actively engage with them. He had needed to explain what the upcoming elections were about, as this was not clear from the official statement. He noted that there was no agreement between Cochrane and Cochrane Work or the Finnish Institute of Occupational Health about what he could and could not put on his website, and he asked Tovey "in which capacity you are ordering us to take material from our website."

Jos invited Tovey do discuss this on the phone, and he wrote afterwards:

"You wanted me to withdraw … two statements about Peter Gøtzsche and one plain language version of the official invitation for candidates for the elections … The reason for removal of the Peter Gøtzsche texts that you gave was … that there could be no criticism of the Governing Board on an official website.

I argued that the website is not the official Cochrane website but the website of the Cochrane Work community. Very few of my occupational health community understand the situation and they very much appreciated my explanation of the situation ... We also discussed that Cochrane has marked all their websites with a copyright sign and that this would mean that all texts are owned by Cochrane ... this sign has been put there without any agreement or even notification.

All texts that are on the site are produced by Cochrane Work paid for by the Finnish Institute of Occupational Health. Since we don't have any agreement about the contents of the websites, this is owned by my employer FIOH ... If Cochrane wants to own the content on all their websites, we have to revise our collaboration agreement ... I would be happy to move all content outside the Cochrane network and return to the previous situation where we had our own website ... you told me that 'they' would not let this situation persist ... I assume we have a conflict as mentioned in our collaboration agreement and I propose to follow the procedure."

This is significant. Wilson had taken control over all Cochrane websites secretly, with no prior process and even without informing those who had constructed them, and he had now become a plural concept, like the royalty: "They" would not let this situation persist. Jos's information about the upcoming elections of four new board members was also plain talk,[1666] in contrast to Cochrane's official announcement:

"With all your hard work for Cochrane, this is the benefit you have earned: you may vote, and you may stand as a candidate in the elections. So, use your rights! It would be foolish to throw away this dearly earned benefit. In this election, Cochrane is especially seeking candidates who are prepared to step into the mess that the current Governing Board has created.

As you may recall, four elected board members resigned because they could not support the decision to expel one of their members. So, it is not going to be an easy job ... This is an exciting opportunity to join the team providing strategic oversight to Cochrane, making sure its decisions are democratic and in the interest of its members. This means that the production of systematic reviews becomes more efficient and leaves less back-breaking slavery for authors … Unfortunately, Cochrane cannot give you any money for doing the ungrateful work of a board member because that is legally forbidden for a UK Charity. You are expected to go through hundreds and hundreds of pages riddled with management talk and filter out the important pieces."

There were 18 candidates for the election. Jos constructed a member's guide, outlining whether they in their election statements had stated anything that was relevant for his four suggestions for change, and what they had stated. But Big Brother was watching him. He was not allowed to use the Cochrane email lists to inform people. Lucie Binder from Wilson's office wrote a message to him on 22 November that doesn't make much sense:

"Cochrane places high regard on minimizing bias, promoting access, and enabling wide participation. For these reasons, canvassing for specific candidates in board elections is prohibited. Candidates standing for the board have not been asked to respond to the 'four major policy issues' you have raised. They have been asked to respond on essential issues for effective organisational governance …

Your correspondence today to Co-ordinating Editors, Managing Editors, and the candidates themselves, seeks - whether directly or indirectly - to give advantage or disadvantage to candidates based on criteria they have not been asked to respond to. Further, it may encourage voters to disregard relevant information contained in the Candidate Statements.

I request that you stop using Cochrane's official email lists or websites to disseminate your correspondence on this issue. I have also delayed the opening of voting by 24 hours while I take external advice on whether the integrity of this election has been compromised. After voting opens, the Central Executive Team will send a series of reminders to eligible voters, supported by community news pieces that will provide the opportunity for voters to get to know the candidates better."

Binder wrote to the candidates that they should not respond to Jos's email. Cochrane was in ruins and its censorship was similar to that of the Chinese Communist Party, also when the Central Executive Team would send community news pieces that would provide the opportunity for voters to get to know the candidates better.

Jos explained on his website (no longer active), what happened next. He wrote to Wilson because Binder wasn't available. Wilson stated that he did not owe any apologies to anyone, and when asked for the legal advice on the elections, he asserted that this was legally privileged information!

In spite of another dozen emails with the board, Jos did not succeed in finding out what the legal advice was. The reason why I was expelled was also legally privileged information. Cochrane had become a bullshit factory.

Ironically, a Mark Wilson signed Jos's petition, but it was the good Mark Wilson, a Canadian bioethicist. This resulted in an angry email from Tovey and another Cochrane leader in which they repeated that what Jos was doing was very damaging to Cochrane.

So, he who destroyed Cochrane did nothing wrong whereas he who told people about it, destroyed Cochrane, right?

Jos was very sharp but why was he so daring? Because he would likely retire soon. Wilson could not harm him.

During the Cochrane meetings in Krakow in April 2019, Jos's resistance group met, too, and there were many interesting comments: The leadership was unwilling to admit mistakes; emails were censored; and Wilson's office held back emails. A call was made for allowing anonymous complaints. People were afraid of being punished by Wilson if they complained about anything, including about the quality of a Cochrane review. This information was also removed from Jos's website. But I found a tweet from the Austrian Cochrane Centre:[1667] "Emails to the Directors list are held back for days by CET [Central Executive Team] or not sent at all. Presumably based on content. This does not allow debate and borders on censorship." Matteo Bruschettini, whom I helped establish the Swedish Cochrane Centre, replied that he would be "happy to provide the evidence to prove" that this was correct.

Jos gave an account of the first 100 days after my expulsion, which was also removed. He explained that three of the four members of the board who had resigned stood in the large lobby in Edinburgh and looked disappointed and forlorn. The most motivated Cochrane members on the board had resigned and the board forced them to take away their statement about why they resigned, yet another instance of falsifying Cochrane history. To preserve the historic record, I put it up on my website.[1668]

Jos wrote that, as evidence that no serious damage was done to Cochrane, the board presented the count of news pieces: "250 about Cochrane and only (!) 65 about Peter Gøtzsche." He noted that all the major medical journals and all newspapers covered it, which was big damage to Cochrane, but the board was in full denial. Jos talked to many people at the Colloquium who agreed that the way in which the board had expelled me was outrageous, "What had happened to him could happen tomorrow to anybody in Cochrane."

Paul Garner and Clive Adams supported the board and applauded my expulsion. Adams was bitterly offended that I had criticised that his Cochrane Schizophrenia group had taken money from the drug industry. I never understood why Garner went from supporting me to supporting the Cochrane tyrant and I asked him about it several times, but he didn't reply.

Lisa Bero had called Jos to ask why he supported me because it should be clear to everybody how badly I had behaved over all those years. Jos replied: "I have read everything, and I have heard many stories. None of these stories have given me the idea that Peter has misbehaved in such a way that he couldn't be a member anymore."

About Cochrane censorship, Jos wrote: "I had put on our Cochrane Work Review group website my account of the affair around the expulsion of Peter Gøtzsche. It was surprising that this was allowed because all other websites were censored by the London CET [Central Executive Team] … I had noticed what had happened to the Nordic Cochrane Centre where the website looked like a forest after a war thanks to the CET."

## Mark Wilson got me fired from my job in Denmark

Wilson changed our website behind our backs in a totalitarian action that only served to humiliate and demoralise my staff, leading to additional collateral damage. I discovered this via a journalist, two weeks after my expulsion.

Wilson secretly deprived us of our administrative rights; deleted me among the staff, although I was still employed; removed our tweet column, @CochraneNordic, which mentioned our published criticisms of two Cochrane reviews, including the HPV vaccine review, and replaced it with @CochraneDK; removed my much appreciated article about Cochrane's moral governance crisis;[1669] and uploaded the untruthful and deeply defamatory statement from the Governing Board about me on the front page.[1670]

This was so much over the top that, when I found out, on Friday 28 September, I wrote to Wilson that I withdrew the Nordic Cochrane Centre from the Cochrane Collaboration.

I immediately phoned my boss at Rigshospitalet, Vice Director Per Jørgensen. He had always appreciated my work, and his only worry was whether the grant from the Danish Ministry of Health to the centre and the other Cochrane groups in Denmark would be affected. I assured him this was not the case, as there was nothing in the Bill of Finances saying that the centre needed to be part of the Cochrane Collaboration.

I wrote to the Ministry the same day, and again on the Monday, explaining that if they did not agree with my decision, it would be very easy to change it, as it was very attractive for Cochrane to have our centre in the organisation.

I thought I was safe, but the injustice I experienced in Cochrane led to further injustice in Denmark. I was fired, and Wilson played a role in this. Removing me from Cochrane wasn't enough for him, he had to kick me while I was down and get me fired from the hospital and from my professorship at the university.

The Ministry knew that my withdrawal of the centre from Cochrane had not been effectuated because Wilson didn't accept it, arguing that as I was expelled from Cochrane, I could not make such a decision. Nonetheless, the Ministry informed Rigshospitalet on 12 October that it withheld payment of the annual grant till the centre had met the conditions for payment!

On 12 October, I held my centre's 25th anniversary research symposium. I had asked Tom Jefferson to tell the audience why we should not use Tamiflu for influenza, but he started his talk with something else that made the audience laugh out loud:


Wilson

Voroshylov, Molotov, Stalin and Yezhov

Voroshylov, Molotov and Stalin




This is the shortest summary of Cochrane's moral collapse that exist.

Cochrane synonymous with one man, its CEO Mark Wilson. He purged his opponents and removed any trace of them, like Stalin did. Tom could very well be next in line to disappear. And Burton, the captain on the bridge, followed orders, sank the Cochrane supertanker, and smiled during his misdeed.

On 29 October, Per Jørgensen and Personnel Manager Mette Risak called me to a meeting where I was summarily and brutally told, with no process at all, that I would be fired, and they didn't give me an adequate justification.

It was my first official call ever, but I was treated as if I had committed a serious crime. I was not even allowed to go back to my office, and my staff were banned from contacting me, which they could not understand the reasoning behind. My five PhD students wrote to the hospital and the Minister, Ellen Trane Nørby, and pointed out that they could not carry on with their work without me as supervisor. But as in Cochrane, the leaders didn't care what the consequences were.

During the meeting, Jørgensen and Risak said that they preferred to avoid a dismissal. They wanted me to accept a "mutual agreement on resignation," with a few months' extra salary beyond the three months I would receive in any case, if I accepted this lie.

The subsequent negotiations between my union representative and the hospital resulted in an offer of 10 months' extra pay. This was extraordinary, and my representative was proud of her result, while I took it as an indication that the hospital had a very bad case that would not withstand public spotlight. And of course there was a catch. The hospital wanted to gag me: "There is agreement between the parties that the content of the agreement is not communicated to third parties. Announcement to employees and relevant internal and external partners will be agreed with the [hospital's] Executive Board. The agreement is the complete and final decision about any claim between the parties without prejudice."

I do not accept attempts at silencing me and robbing me of my opportunity to tell the truth, which Wilson had tried. I replied, copying the Ministry, that my freedom of speech was not for sale and that what was going on should come to light.

Jørgensen's official reason for firing me was that he had lost confidence in my ability to lead the centre. This was not an objective reason, and it contradicted totally the scientific success of the centre.

On the advice from the former Ombudsman in the Danish Parliament via a mutual friend, Margrete Auken, I engaged a top lawyer. Through the Freedom of Information Act, we got access to various documents and learned that the Ministry and Rigshospitalet since 1 October via Wilson's emails had been fully aware that the centre continued to be part of Cochrane.

The Ministry and the hospital kept this knowledge to themselves, and Jørgensen lied about it at a meeting with my staff on 5 November. When he tried to explain why I would be fired, he continued to give the impression that the centre was not part of Cochrane, even though he knew this wasn't true. The conditions for the release of the grant had been met all the time, but he did not convey this information.

Wilson had required that I must no longer work at the centre, and the Ministry and Rigshospitalet had cowered to him, although, according to Cochrane rules, I could continue working as chief physician while my deputy handled Cochrane-related tasks.

It was outrageous that Cochrane's CEO aggressively pushed authorities in a sovereign country to dismiss a person from his job in that country and that the Ministry and the hospital seemed to have used all means at their disposal to accommodate Wilson's vindictive requirement that I must be fired, even though 50 employees suffered as a result, as they were very afraid of losing their jobs. This uncertainty lasted over two months.

I told several speakers on health in parliament that they had been misinformed by the Minister who seemed to have been misinformed by her Head of Cabinet, Per Okkels. They promised to talk to the Minister about it. On 11 December, I wrote about it a newspaper,[1671] which I translated into English, *My dismissal is scientific judicial murder.*[1672] I noted that, instead of silencing an important voice, Rigshospitalet and the Ministry should protect me. Sacking me would send the unfortunate signal that if your research results are inconvenient or threaten the pharmaceutical industry's earnings, you might be fired. Strikingly many of the documents my lawyer obtained from the Ministry were articles where healthcare stakeholders - psychiatrists, other doctors with conflicts of interest, the Board of Health, the Drug Agency, and editors of journals financed by the pharmaceutical industry - had tried to depict me as untrustworthy hoping that I would one day be removed. It was scary to see the results of this massive lobbying. It is dangerous to speak truth to power.

I noted that my situation was the result of a power struggle between two wings, Wilson's and mine, and explained what the differences were. I suggested that the centre changed status and name to Centre for Evidence-Based Medicine, like several other Cochrane centres considered doing, as it would be of greater value to their home country than to be a member of an organisation that did not live up to its declared values.

There were hearings, but it didn't matter that my lawyer and I documented that the arguments for firing me were untruthful, and that Wilson had lied to the Ministry, e.g. by saying that I had not lived up to my obligations according to the Memorandum of Understanding. My lawyer noted it was an aggravating factor that neither the Ministry, nor the hospital, had investigated if Wilson's postulates were true but had used them to fire me.

Even after I had shown it was incorrect, my employers continued to lie by claiming I had endangered my centre's existence. They also claimed that my centre could not be a member of Cochrane unless I was fired, which they also knew was untrue, as David Hammerstein had informed the hospital and the Ministry about the rules. There were several other untruthful statements and contradictions. For example, I was told that my attempt to withdraw my centre from Cochrane was immaterial, as the centre had never been withdrawn, but why did the Ministry then withhold the annual grant and why did my employers lie about it?

After a lot of back and forth, I stopped working on 30 April 2019. I dropped the idea of a lawsuit, as my lawyer was not sure we would win. Moreover, it would be very burdensome, expensive, and emotionally painful, perhaps lasting several years. It was better that I put it all behind me and entered a new phase of my life.

However, I worked on launching a court case in London against defamation, a "no win no fee" deal, and David Magill from Simon Burn Solicitors thought I had a good case. He spent a lot of time preparing my case for a barrister who would represent me in court. When he had found one, David Hirst from MyBarrister, I was told that I should pay him £10,000 for writing two letters asking for settlements out of court, which I could easily have drafted for him. Even though the offer was reduced to £5,000 after I had protested, I wondered what the next demand would be. Magill had told me he could contact several barristers, but he lost interest when I declined to pay any money. I am convinced they had set up a trap for me, thinking that when I had come this far, I would likely not back out. But I am not that stupid.

I was surrounded by dishonest people everywhere, in Cochrane, in London, and in Copenhagen. What a world this is. It takes many years to build a successful research centre, but only a moment to destroy it. My centre never became the same after my dismissal and was rather silent in the public debate. It became part of the Centre for Evidence-Based Medicine in Odense headed by my former deputy, Asbjørn Hróbjartsson, which meant the employees had to travel 164 km to get to work, which caused some of them to quit.

## Attempts at preventing my dismissal

David Hammerstein organised a petition he sent to the Minister of Health requesting she overturn my sacking. It had over 10,000 signatures, including Cochrane's founder, Sir Iain Chalmers, *BMJ's* editor, Fiona Godlee, John Ioannidis from Stanford University, the world's most cited healthcare researcher, MEP Margrete Auken, and psychiatrist David Healy, one of the world's leading experts on psychiatric drugs. I have uploaded some of the letters of support people sent separately to the Minister.[1673]

David mentioned in his petition the great benefits taxpayers, patients and healthcare professionals reap from my work and that my dismissal could harm the international reputation of Danish medical research and seriously weaken Denmark´s traditional support for open scientific debate.

Thousands of people argued why I should not be fired, and here are some examples:

Thomas L Perry: I have been Minister in the Government of British Columbia. One of the scarcest resources available to elected decision-makers is scientific objectivity and truth. Dr. Gøtzsche has inspired thousands and enhanced Denmark's reputation for over 2 decades. Do what you can to discourage a leading hospital and university from penalising a doctor who tries to protect sick people and other humans from ignorance.

Richard Stantiford: When I read something from Peter, I instinctively know it is the truth! Do not punish this incredible scientist.

Janel Hopper: Peter Gøtzsche is an international treasure. Remove him and you'll look like a bunch of crooks.

Anne-Marie Krogsbøll: Sacking Peter Gøtzsche would be a crime against science!

Sam Stone: What a coincidence that the member they are expelling is a harsh critic of Big Pharma.

Nick Mailer: The forces of darkness attack medicine's Galileo.

David Colquhoun: I could scarcely believe that there is a possibility that Peter Gøtzsche might be fired. To do so would be to capitulate to pressure from big business and corrupted administrators and/or clinicians. It would make Denmark itself look corrupt and vindictive. He should be promoted, not fired.

Juan Gérvas: For most doctors Peter C. Gøtzsche is *the* Cochrane Collaboration, and *the* Nordic Centre of Cochrane. There is no other name that represents in the world such a model of scientific honesty. His works have given prestige to Denmark and its science.

Ryan Horath: Dismissing Gøtzsche would do enormous harm to the citizens of Denmark and the world. The future will no doubt view such a decision harshly, just as it will view Gøtzsche's expulsion from Cochrane. The Cochrane leadership is desperate to save face in this embarrassing mess they have created … reject this intimidation and stand up for science over money and power.

John Read: Dr Gøtzsche is being victimised for upholding the highest scientific standards to expose the shortcomings and dangers of psychiatric drugs. His dismissal is a disgraceful succumbing to vested interests and an abandonment of academic freedom.

Rudi Leibik: Firing this respected researcher would send a strong message that freedom to report research findings is no longer a protected right, and that facts that do not support/ condone certain ideologies present a threat to one's very livelihood and reputation.

Anthony Miller: Peter has revealed the truth behind mammography - the Cochrane Foundation should be proud of him for this, I am sure Archie Cochrane would have been.

Angela A Stanton: Dr. Gøtzsche is a terrific doctor with the medical oath in mind and heart. Firing him would not only be sad for him and his family but will bring shame to an institution, whose job is to improve health rather than prescribe medications.

Nina Teicholz: How can "making too much noise" be a firing offense? In science, and in the fight for truth, it is sometimes necessary to make noise to be heard.

Nortin M Hadler: Dr. Gøtzsche´s work at the Nordic Cochrane Centre has been exemplary and far reaching in importance. Any punitive action by his home institution on this basis would be a travesty comparable to the unconscionable action of the Cochrane administration.

Daniela Junqueira: The dispute Cochrane has sustained against Dr. Peter Gøtzsche has its roots in the company's concerns over having been criticized. Criticism is vital to research progress, and it should not be attacked this way.

The people who wrote to the Minister included:

James Wright, editor of the Cochrane Hypertension Group and Director for the Therapeutics Initiative, University of British Columbia, wrote that I was a leader in identifying the settings where the harms of interventions outweigh the benefits, which had benefited hundreds of thousands of patients worldwide, and that he was devastated to learn that vested interests were now impacting Cochrane. He noted that the patients and the public would be harmed by my dismissal, and that independent, non-conflicted investigators looking at evidence for healthcare interventions were few and far between.

Thorkild IA Sørensen, previous Dean at the Faculty of Health and Medical Sciences at the University of Copenhagen, considered it totally unacceptable that Cochrane allows conflicted authors and drew a parallel to the Administration Act's principles of impartiality in the assessment and treatment of a given case, noting that if this is not the case, the credibility of the conclusions vanishes, and they become essentially useless.

Alvaro Atallah, Director of the Brazilian Cochrane Centre, number two in Brazil in terms of having published the greatest number of systematic reviews in all scientific fields, wrote that I was paramount in establishing the current standards of evidence-based medicine and that he admired how seriously I take my scientific work and how I had made doctors the world over hold Denmark in high regard.

Olga Runciman from the Hearing Voices Network in Denmark explained they had made me their Protector because I am a fearlessness, honest and powerful voice in psychiatry based on sound research, a voice that reflects so many of the experiences of voice hearers. Dismissing me would send a powerful message to the world that freedom of academic speech is no longer a protected right, and that those who do not condone the ideology of psychiatry risk their very livelihood and reputation.

John Ioannidis wrote that he had unconditional admiration for me. “Peter is undoubtedly a giant, one of the greatest scientists of our times and one of the most influential, impactful, and useful voices in medicine at large. I cherish enormously his contributions. I believe he is the most recognizable and prominent scientist that Denmark currently has. His dismissal from the Cochrane board two months ago came as a total shock to me. The possibility of compounding this shock with his dismissal also from the Rigshospitalet would deal a severe blow to medicine, democracy, freedom of thought, and justice. I believe that basic respect for scientific discourse requires that you do not eliminate your opponents through administrative machinations. Ousting Peter from the Rigshospitalet damages the reputation of Denmark as a free country.”

John also published a scathing criticism of Cochrane’s leadership:[1674]

“Secrecy is perhaps the most damaging part of this sad story ... Despite the statement of the Board that what has happened is not about freedom of speech, scientific debate, tolerance, dissent, or criticism, it is precisely these issues that unavoidably surface in this clash ... Expelling an elected member of the Board who expresses a different viewpoint with some vague excuse that cannot even be disclosed does not befit a scientific organization ... It is inappropriate to silence opponents with administrative machinations ... This brouhaha exposes a crisis at the core of the Cochrane leadership and its core values. It is worrisome that neither the remaining Board members nor the Cochrane CEO have a particularly strong track record in what Cochrane became famous for: evidence-based medicine and high-quality, independent systematic reviews ... Expulsion of dissenters, intolerance, secrecy, and emphasis on resolution of debates with administrative intrigue and vague, unsupported proclamations rather than by data creates serious damage. Repeated use of strong language and using words written in bold letters cannot replace disclosure of facts and evidence ... The position that the alleged bad behaviour needs to remain undisclosed has become entirely untenable, given this evolution. Without sufficient documentation and open explanation of their **unusual and suspect** actions (and I put “unusual and suspect” with bold to follow their style), the behavior of the remnants of Cochrane leadership cannot be easily differentiated from a combination of slander, administrative incompetence, and character assassination. If they have solid evidence against PG, they should be transparent about declaring it ... at a minimum they should safeguard their integrity, accountability, and leadership by resigning.”

Johns's analysis is very sharp. He also asked if Cochrane had been hijacked, as it is clear that it does not keep industry at arm's length. The science has been hijacked by Cochrane apparatchiks like Wilson without vision, with no competence in clinical trials or meta-analyses, with no grand plans, but with hundreds of carefully executed details. Under his rule, Cochrane bureaucrats tried hard to impose their views onto senior scientists and they put spin on Cochrane findings without being able to discern if the reviews were reliable.

The Cochrane spin is called Knowledge Translation. In 2017, while I was on the board, I criticised a long report about this that it had taken a year to prepare. The experts in communication that had been involved were unable to communicate to us what they meant. It was words, words, words. I couldn't find anything concrete that told us what we should do. I jokingly asked at a meeting where the report was presented if I was supposed to find a soapbox in Hyde Park and a megaphone and yell in all directions: "Come and read the latest Cochrane review." I have probably done more knowledge translation than anyone else, but without any spin on it.

In Gerd Antes's view, this amateurism, where we were pestered with empty management speak with buzz terms like "Knowledge Translation," might mean that Cochrane would disappear in absolute irrelevance in a few years' time. My wife repeatedly called Cochrane the amateurs' paradise, also many years before I was expelled.

The Cochrane bureaucracy was outright funny when John, in mid-December 2018, after publication of his devastating criticism of Cochrane received an automated e-mail: "Dear John PA, we are very pleased to inform you that your contribution to Cochrane has earned you the right to Cochrane membership!" Cochrane robots do the job.

## Where is Cochrane at today?

In January 2019, journalist Melanie Newman published a devastating criticism in the *BMJ* of Wilson's leadership, *Has Cochrane lost its way?*[1675]

When Iain Chalmers started the Cochrane Collaboration in 1993, he had "Challenge authority" on his T shirt. The collaboration, he said, should be "committed to opposing any tendency for it to become dominated by any nation, institution, or individual." But Cochrane became one man, Wilson. Shortly after he arrived, a video was sent around comparing the Cochrane leadership to "Hitler and his high command," Newman wrote.

Tom Walley, former director of the UK National Institute for Health Research (NIHR), agreed that Cochrane needed to change: "It has become a machine, churning out reviews … Cochrane should focus less on quantity and more on methodologically high quality reviews in areas of importance to patients. It needs to be more iconoclastic, more challenging, and more of an advocate for evidence based medicine."

Newman mentioned my name 21 times in her article, e.g.: "many viewed Gøtzsche as a champion of truth and research quality, and if some thought he sometimes went too far, many others admired his uncompromising stance."

The criticism of Cochrane started before Wilson kicked me out. In 2016, I sent some critical remarks about Wilson's five-year plan to two Cochrane directors noting that Paul Garner had said that, previously, the WHO had asked "Is there a Cochrane review?" when they were in doubt about an intervention. But now they added: "And is it good?"

On 23 April 2021, Professor Ken Stein, Director of the Evidence Synthesis Programme at the NIHR spoke at a webinar about the work in the UK Cochrane groups and their future

funding.[1676] He criticised Cochrane substantially for much the same reasons as I had done and emphasised that Cochrane authors should be iconoclastic. He said the writing had been on the wall for eight years, which was exactly the period when Wilson ruled Cochrane, and announced a major budget cut was likely in 2022.

About the failing scientific integrity, Stein noted that, "This is a point raised by people in the Collaboration to ensure that garbage does not go into the reviews; otherwise, your reviews will be garbage."

It is highly unusual for a top funder to say that the recipient of the funding must ensure that garbage does not go into the research. This suggests that Stein was aware that Tom Jefferson had said that "If your review is made up of studies which are biased and in some cases are ghost written or the studies are cherry picked and you don't take that into account in your review, then it's garbage in and garbage out … with a nice little Cochrane logo on it,"[1677] or had read my first book about Cochrane's moral collapse. Jos Kleijnen told me that Stein was present in Edinburgh and knew I had been expelled.

Wilson suddenly left his job, seven days before the webinar where Stein announced that a major budget cut was likely. There was no farewell message from him, which was highly atypical for his narcissistic character. According to the Governing Board, he left "for entirely personal reasons."[1678] The co-chairs, now Marshall and Howe, acknowledged his "huge contribution" with "eight years of outstanding service."[1679]

Wilson got another job five months later and currently works as Director of Becadia Consulting Ltd. Wilson started this company on 31 May 2022 with Jo Anthony, who was head of Cochrane's Knowledge Translation department.[1680] Gerd Antes told me that Wilson, a married man, was kicked out of Cochrane because of a love affair with Anthony, which Iain Chalmers had also heard about. So much for the "entirely personal reasons."

What Wilson does in his new company is not clear. The nature of the business is management consultancy activities. I could not find any website for the company, which is very odd. Another website states that Wilson joined Health Exchange as interim CEO in May 2022 to provide strategic advice and support through his company.[1681] Official records show that the net assets were £55,137 for the first 22 months. But Wilson has not given up on his habit of boasting. On LinkedIn, he says that he is "An innovative, decisive problem solver and expert in strategy, governance, international operations and communications."[1682]

I would call him an expert in destruction. He boasts about what he achieved in Cochrane, including that he increased his staff from 20 people to over 120. On the title page in my first book about Cochrane, I write that "A wrong leader can destroy what 10,000 people have built up patiently over 20 years … I dedicate this book to the more than 10,000 volunteers in the Cochrane Collaboration." These people worked for free, generating the wealth that Wilson abused by creating a huge staff and a highly inefficient organisation.

What I have heard in evidence-based circles is that the damage Wilson and Burton caused is irreparable. Cochrane remained afloat for another three years after my expulsion, but it started sinking four months after Stein's webinar. In August 2021, the NIHR informed Cochrane review groups based in England that it would cease their funding at the end of March 2023. On that date, funding for Cochrane in the UK ended, after 31 years of support. The loss was around £5.3 million annually.[1683] The NIHR ended the financing to develop its own evidence synthesis programme. Cochrane had moved too far away from publishing evidence that could inform UK practice and was too long-winded.

Cochrane was in big disarray, and the questions and answers on the Cochrane website told a story of considerable confusion.[1684] As John N Noble wrote on an email list, nothing

would change unless the recommendations of previous critiques were implemented. He added that to continue "flogging the Cochrane Review dead horse" won't make it run.

In November 2021, I could no longer find the message on the Cochrane website that I saw two months earlier about the loss of funding and Cochrane's confusion: "Access denied. You are not authorized to access this page." A worldwide charity like Cochrane should not delete important messages. I found another website saying that "from Q4 2023 the editorial process for all Cochrane evidence syntheses will be managed through the Central Editorial Service."[1685] This message was undated, which is also unprofessional.

Wilson obtained what he wanted: Total centralisation in Cochrane and destruction of the organisation. The many review groups stopping doing editorial work. In December 2018, someone discovered that Cochrane centres had ceased to exist. In the description of the various Cochrane groups on the website, this word has been deleted and centres were now called "Geographic groups." Another example of management by stealth.

Wilson once told me he loved fights because he always won them. He was also confident he would win his fight with me. But did he? He abused Cochrane for his own purposes and took the whole Cochrane Empire with him in his fall. I feel sad about what he did to this once magnificent organisation. The game is over. But I am fine. I sometimes think about what would have happened if I had become the new CEO when I applied for the post in 2012. I had many visions about how Cochrane could be improved and my management philosophy was the direct opposite to Wilson's. I kept bureaucracy to a minimum and gave my staff a lot of freedom, which is a very productive strategy, and my centre attracted highly skilled people because it was widely known how much fun it was to work there.

My personal story is not important. I just happened to be the person who didn't give in to Wilson's brutal reign and therefore paid the ultimate price, as they say. As you have seen, this story is much bigger than me.

In 2017, the NIHR provided core funding to 21 Cochrane review groups based in the UK out of 52 worldwide.[1686] I did a search in March 2025 to find out who currently funds Cochrane. The Cochrane website is untruthful.[1687] It says that the "NIHR is the largest single funder of Cochrane, and currently supports 21 Cochrane Review Groups based in England." None of the UK review groups have core funding any longer from the NIHR but need to apply for grants. Most of them have been closed for this reason.[1688] It seems that only a couple of UK groups are still existing but likely not for long.

The Danish Government is now the only institution in the world that contributes over £1 million annually to Cochrane. I believe it is time for Denmark to follow the British example and stop all core funding of Cochrane activities. It is no longer worth it.

In December 2021, I did a search on YouTube on *Cochrane Collaboration,* which showed that three of the top ten most viewed videos were about me. The top one was an interview about organised crime; the next was my lecture at CrossFit about Cochrane's moral collapse; and the third was a 2014 interview where I explained what the Cochrane Collaboration is.[1689]

In January 2025, I found out that Cochrane's two defamatory statements about me were still on their website. I required to have them removed and asked 17 questions related to the show trial,[1690] e.g. what my so-called bad behaviour was about.

Cochrane reacted by taking down one of their defamatory messages from their website. They wrapped up their reply in legal terms, but there are no rational grounds for removing a public statement of this nature unless they are aware that it cannot be substantiated. It is extraordinary for a well-known organisation to take down information they themselves have

published about a concrete person, and even though they didn't admit guilt, it is difficult to interpret it otherwise.

I required in a second letter[1691] that they also take down the other, even worse defamatory statement and Burton's hate speech about me on YouTube and respond to my questions. They did that and also removed the defamatory video from YouTube that showed Burton's hate speech.

What happened to those who expelled me? They relatively quickly disappeared out of public sight, apart from Marshall and Howe who became co-chairs, and Joerg Meerpohl who is currently a board member again.

Cochrane News do not reflect the massive problems Cochrane has. It is spin all over about how wonderful everything is: "Cochrane is in a strong position," "a world-leading source of trustworthy evidence," "incredibly talented and loyal colleagues," "All have worked hard to ensure that Cochrane has a great future and is a wonderful environment in which to work and grow," and it "has a warm and collaborative culture that fosters innovation and trust."[1692]

# 15 Life after Cochrane

Wilson's Stalinist manners cost me my job. And opened my eyes. David Hammerstein told me I would get a better life after my excommunication from the Cochrane church and he was right. It was not meaningful to work for an organisation Wilson had systematically destroyed and developed into a bureaucratic monster.

Journalists have often asked if I have many enemies. Yes, millions, but my friends are some of the bests you can imagine. People who are willing to suffer or even die for their moral principles are some of the most amazing people you can meet. They become resistance fighters if their country is occupied by a foreign power, but there are few of them.

Three months after my book about organised crime in the drug industry had come out, I was in Boston and a radio host in New York interviewed me live for half an hour. By the end, she suddenly asked if I was not afraid of ending up at the bottom of the Hudson River with my feet in concrete. I replied that the risk I ran was minimal, compared to the risk my grandfather ran during the war. Being a doctor, he was allowed to drive at night, and he helped Jews escape to Sweden who often stayed in his house before the transport.

Traitors were paid huge sums by the Gestapo, and he was betrayed. The Nazis came to his house one night accompanied by the worst torturer Denmark had during the occupation: Ib Birkedahl Hansen. He was Danish and became the last traitor to be executed after the war after a protracted process where he tried to fake insanity to survive.[1693] My stepfather was also taken by the Gestapo. They shot his prison mates.

In June 2018, I lectured at the Max Planck Institute for Human Development in Berlin for young researchers from all over the world as part of a new series of lectures, *Heroes of Science*. I was one of the two speakers, and my lecture, *Survival of a whistleblower*, was filmed.[1694] I explained that you can go against the grain and be true to what your research has shown, criticise the results of influential people, and still survive. I also said we should not fear tyrants and reminded the audience of the Nazi atrocities.

My grandfather was taken to Gestapo's headquarters in Copenhagen where he was threatened with torture and was told they could rape his wife and daughter, my mother. He remained calm and was not tortured. He spoke fluent German and established a good relationship with the Nazi officer who interrogated him. They had a common interest in religion and music, and it also played a role that the Germans knew they would lose the war.

My grandfather was a great amateur pianist. Like Victor Borge, his lecturer was the most famous Danish pianist at the time, Victor Schiøler. Schiøler was so impressed by his pupil when he played the most difficult of Beethoven's sonatas that he wanted him to become a classical pianist for a living. I have all the sonatas and have played a few of the easier pieces.

This moved the Nazi but my grandfather was nonetheless going to be deported to a concentration camp outside Leipzig. However, because the Allied Forces had destroyed the train tracks in northern Germany, he ended up in the Danish Frøslev camp on the border. When the Allies stood outside Leipzig, the Germans poured petrol over the barracks where they had chased all the prisoners together and set it on fire to leave no witnesses of their atrocities. There were almost no survivors. Those who ran out of the barracks were shot or committed suicide by running into the electric fence.

After the war, my grandfather spent three months in Poland helping the best he could. He wrote about his experiences in a book about doctors in the resistance.[1695]

In 2001, I sold my Opel Vectra and the buyer's father came to fetch the car. When he saw my name, he started speaking about the war. He and my grandfather had worked closely

together and one day, they had planned to shoot a traitor in the forest close to Haslev, the little town where they lived. It was a local shoemaker who had betrayed several freedom fighters to Gestapo. Unfortunately, he sensed something was wrong and didn't show up.

When the old man told his story, his eyes filled with tears. He had shot someone and never forgot how terrible it was even though it was the right thing to do. He always had a cyanide capsule in his mouth during these actions and would have killed himself if he got caught as he could not endure the torture without revealing names of his comrades.

My grandfather inspired me greatly. He did what he believed was right. During a war or other times of great distress, you find out who you can trust and that some people you trusted are ready to betray you. We should not be obsessed with our safety, but focus on having a good life. Karen Blixen, the author of *Out of Africa,* wrote that if our life has any value, it is that is has no value: Those who can die, live freely. We live near Blixen's home in Rungsted, and look at the fields from our dining room that were owned by her nieces.

My grandfather died in 1987. His wife was a very caring person whose main role was to keep him out of trouble, as he was outspoken and could be direct. They often said they loved me, which is unusual in our culture, as this is what lovers say to each other.

A year after I gave my talk in Berlin, my situation was radically different. At CrossFit's headquarters in Santa Cruz in California, my lecture was *Death of a whistleblower and Cochrane's moral collapse*, which I repeated in Madison, Wisconsin.[1696] Its co-founder, Greg Glassman, had read all my books and was appalled about Cochrane's misconduct. One day, in the spring of 2019, he and several of his directors rang me and said they wanted to support me.

They paid a huge sum for my lectures, and I wrote some articles, for which they also paid handsomely, and they arranged for me to try CrossFit at home. My wife and I weightlift twice a week, and our oldest daughter Pernille also joined CrossFit where she met her husband Mathias. It's fun to become stronger instead of losing muscle strength, which usually happens when you get older.

While I was in Santa Cruz, Michael Baum and two of his associates from his Los Angeles law firm came up to see me, as they wanted to hire me as an expert witness for their lawsuits against Merck (see page 289). Michael collaborates with Robert F Kennedy Jr., who is also a lawyer, and he came up to see me, as he considers me a world leader in exposing the crimes in the drug industry. We have kept contact, even during his Presidential campaign in 2024 and also now when he is secretary of health. During the hearings in Congress related to his nomination, he mentioned on both days[1697] that I had shown that our drugs are the third leading cause of death. As already noted, my more detailed analyses have shown that our drugs are THE leading cause of death in the United States.[1698]

It is a relief that I shall never again be harassed by small bureaucrats and bookkeepers with psychopathic traits who don't know what science, pioneering work, genuine leadership, respect for other people, or freedom of speech is about.

I currently work as researcher, lecturer, author, independent consultant, interviewer and filmmaker (see below). I have been an expert witness in lawsuits in Alaska, California, New York, Canada, Norway, Denmark, Holland and Australia. It is stimulating work to disentangle the spider's web of issues in lawsuits, which is similar to my research detective work, hoping I may contribute to killing the spider.

## Institute for Scientific Freedom

US Psychiatrist Peter Breggin from Ithaca did me a great favour. We had lectured together several times and in Tampa, Florida, where Bob Whitaker also lectured, he presented us as the dream team. I have been much inspired by Peter's books and other writings.

In November 2018, Peter said I should open an institute to carry on with my work and a donation account. To my great surprise, generous people donated over 300,000 crowns before I closed the account and opened a new one to support my filmmaking (see page 419).[1699]

In March 2019, I opened the Institute for Scientific Freedom and held a symposium about scientific freedom in Copenhagen,[1700] which drew attendants from as far away as California, India and Australia, even though we only announced it on websites and social media. All the speakers were whistleblowers: Robert Whitaker, David Hammerstein, Maryanne Demasi, Tom Jefferson, Peter Aaby, Kim Witczak, Peter Wilmshurst, and me.

Morten Hjertholm from Storyboard Productions filmed the lectures for free, as he found our initiative important, and uploaded them on YouTube.[1701] Two and a half years later, YouTube removed the lecture by Peter Aaby, *Most of you think we know what our vaccines are doing - we don't*. YouTube explained that it "doesn't allow content that poses a serious risk of egregious harm by spreading medical misinformation about currently administered vaccines that are approved and confirmed to be safe and effective by local health authorities and by the World Health Organization (WHO)." There were several links in the message but none where it was most needed: "Appeal here."

Morten said that some people had had their whole YouTube channel deleted without any prewarning and without a plausible reason. We appealed and our complaint was rejected. As we were only allowed 800 characters, Morten sent this message instead:

"It is inappropriate that YouTube has removed this video. There is no misinformation whatsoever. Professor Peter Aaby is a top vaccine researcher. He talks about how live vaccines seem to decrease mortality much more than can be explained by their specific effects against a particular microorganism whereas non-live vaccines appear to increase total mortality. Aaby's research has led to changes at the WHO, e.g. WHO recommended against a high-titre measles vaccine. He disagrees with WHO about the DTP vaccine, but Prof Peter Gøtzsche has reviewed the studies. Aaby is right, WHO is wrong. Historically, challenging authorities has been immensely beneficial for mankind and for making scientific progress. This is at the heart of science. I can send a full analysis of Aaby's lecture."

The next day, YouTube informed Morten that they had reviewed the content carefully - social media always say this but I wonder if it is ever true - and had confirmed that it violated their medical misinformation policy: "It's our job to make sure that YouTube is a safe place for all."

This was bizarre. Censoring scientifically valid and important information about vaccines does not make the world a "safe place for all;" it makes the world a less safe place.

Someone likely saw the 2.5-year-old video and complained to YouTube, which reacted robotically. I uploaded the video on my homepage[1702] and published a summary of Peter's lecture explaining why he disagrees with WHO's view on the diphtheria, tetanus, and pertussis (DTP) vaccine[1703] (see page 294).

It is not medical misinformation when an honest, diligent, and clever researcher arrives at another result than what is the officially accepted "truth" and talks about it. We call it good science and good communication.

Three months later, in February 2022, Aaron Siri and Elizabeth A Brehm from a US law firm wrote a 3-page letter[1704] to Susan Wojcicki, Chief Operating Officer, Legal Support, YouTube, asking her to restore Peter's video so that a healthy conversation about medical science could continue. YouTube ignored the letter and sent a standard, robotic reply. The lawyers appealed and received no reply.

I wrote an article about the Institute noting that,[1705] "Scientific freedom and freedom of speech are constantly under attack because of financial, political, religious and other interests. These essential values in democracies get eroded if we do not support them, fight against injustice and provide effective protection for whistleblowers."

The overall purpose of the Institute is to preserve honesty and integrity in science, which should strive to be free from financial conflicts of interest, should be published as soon as possible and made freely accessible, and should make data and study protocols accessible, allowing others to do their own analyses. We will contribute to developing better healthcare where more people will benefit and fewer will be harmed by the interventions they receive.

In the Institute's first year, Tom Jefferson was one of the deputy directors, but he withdrew due to a conflict of interest issue, leaving Maryanne Demasi from Australia as deputy. By the end of my directorship of the Cochrane centre, I had employed both part-time. In 2025, my filmmaker Janus Bang also became deputy director. Maryanne and I currently publish over 100 articles annually, which are listed, with links, on our website.

Science is under attack as never before in recent history. And censorship in scientific journals, the media and in social media increased dramatically during the COVID-19 pandemic. To find ways of tackling this crisis, my Institute and Carl Heneghan's Centre for Evidence-Based Medicine in Oxford held a two-day conference in Copenhagen in October 2022, *Lack of scientific freedom: causes, consequences and cures*.[1706]

As Carl caught an illness and couldn't come, I chaired the whole meeting. This was very stressful. We had attracted some very weird characters with extreme views and whose research was deeply flawed. Some people were highly talkative even though I said many times, very politely, that they should not talk while a lecturer was talking but wait till the discussion. Some were anti-vaxxers and tried to change all discussions in that direction, and some ran away from their restaurant bill. I decided that I would never arrange a conference again. It was worse than having to deal with a very difficult class at school in a socially deprived area where the children had not learned good manners.

Universities should be the natural haven for academic freedom, but they aren't. After the student revolt in 1968, you had a hard time if you wished to study Danish literature at the university and didn't confess to your fellow students that you were a Marxist-Leninist. The intolerance was huge.

During the pandemic, an American noted on an email discussion list that vaccine mandates at universities were okay as a condition for continued employment because academics should be setting a standard for the community. He even said that discussions of the reasonableness of such mandates with the students should not be allowed. A New Zealander said that research and critical thinking are not about setting a standard but about *challenging* the standard. How can universities teach critical thinking if people who challenge the standard de jour are fired, expelled, crucified professionally, treated with disdain or ostracised? I agree. We should not accept fundamentalism or censorship at our universities.

Universities are also very poor in handling cases of academic misconduct. I have given many examples in my books that they prefer to close their eyes, e.g. Karolinska Institutet in Stockholm protected a fraudster and habitual liar, Italian surgeon Paolo Macchiarini, and targeted the whistleblowers instead.[1707] The Institute subjected them to a brutal campaign of harassment and intimidation; threatened them with dismissal; falsely accused one of them of research misconduct, which derailed his research career; and reported them to the police, falsely accusing them of illegally accessing hospital records.

In a democracy, it is not legal for a public agency to tell its employees they are forbidden from speaking to the media, but in practice, this is how it often is. A comedian might say to a journalist: "The person you seek is dead, trekking in Vietnam where she disappeared, just had a stroke and cannot talk, lost her mobile in the toilet, or is on pregnancy leave indefinitely. If you find her, we will punish her for speaking out beyond our control."

Freedom is everything and censorship is deadly.[1708] If there had not been censorship in Nazi Germany, Hitler would have had less support, and millions of deaths might have been avoided. If there had not been censorship in Russia, there would have been less support for Putin's war crimes, and his war in Ukraine might have taken a different course.

Donald Trump won almost half of the votes in the 2020 presidential election even though he spread over 30,000 false or misleading claims during his first presidency.[1709] The worst lies was that the election had been stolen from him because of electoral fraud. Two-thirds of Republican voters believed in that lie, and they still did in June 2023.[1710] Trump's lies instilled so much hatred in his supporters that armed rioters stormed the halls of Congress on his orders on 6 January 2021 to block Joe Biden's win.

This was an attempt to overthrow democracy. But it doesn't mean we should restrict our freedom of speech. It means that our laws should hold people accountable if they spread blatant lies, with stiff penalties, and no presidential immunity, as is currently the case in the USA.

Humour is a good antidote against wannabe dictators like Trump and religious fanatics. I have argued why we should have no law against blasphemy,[1711] and I warned in 2024 against voting for Trump in numerous tweets and in an article after his re-election.[1712] Alas, USA now has a president that is rapidly destroying not only his own country but a lot elsewhere, too.

## Broken Medical Science, our film and interview channel

Sometimes, the written word can be enough. I opened EMA's archives of clinical study reports to the public (see page 111), succeeded to get ads for drugs out of our medical journal (see page 261), and my writings have saved many lives.

But most of the time, you don't get anywhere by fighting with the pen. Documentaries and filmed interviews can be more powerful because they speak to people's emotions and reach many more people because links are propagated on social media. As already noted, the interview where I describe the organised crime in the drug industry in eight minutes, has been seen by over a million people.[1713]

I collaborate closely with one of Denmark's best documentary filmmakers, historian Janus Bang from Fredericia, and we launched a film and interview channel, *Broken Medical Science*,[1714] in September 2023, which quickly gained momentum. We hope people will subscribe to our newsletter and help the patients and their relatives by spreading links to our episodes widely. To speed up our work, we also hope to get more financial support and

we have an account for donations.[1715] Our first documentary film will be *The honest professor and the fall of the Cochrane empire*.

Janus first contacted me after he had read my 2013 book about organised crime in the drug industry,[1716] which has two chapters about psychiatry. He was shocked about what he read, checked my sources, and found out that everything was correct.

Janus has an interest in psychiatry, and we met for the first time in 2015 when I launched my first psychiatry book[1717] at a meeting in Copenhagen I had arranged, *Psychiatric drugs do more harm than good*.[1718] He was impressed that I dared tell the truth but was also convinced that I was such a threat to mainstream psychiatry that I would lose my job.

Janus and I have travelled together to the United States, Britain, Scotland, Germany and Holland. In February 2023, he suggested I should make a filmed podcast channel. The same month, my close friend, psychologist Peer Nielsen, suggested the same. Peer and I had played cards for over 30 years every three months with three friends we have known for over 50 years. We start with a meal, followed by discussions about various matters, and my friends enjoyed when I spoke about my work and all the silliness I encountered in healthcare, in research, and in Cochrane.

Our film channel is unique because it is evidence-based. There are thousands of podcast channels, but the viewers cannot know if what is being said is correct. We provide references for each episode allowing the viewers to check for themselves. It is also unique that the interviews usually consist of one scientist talking to another about subjects they are both familiar with.

What we want to achieve is the same as what Iain Chalmers wanted to achieve when he started the Cochrane Collaboration in 1993. We want to help people make better decisions when they become ill and are offered various diagnostic tests and treatments. One of our reasons for creating the channel is the decline in free speech and scientific honesty that the COVID-19 pandemic aggravated.

Our first episode is *Big pharma, the corruption of science, and millions of unnecessary deaths*, an interview Janus made with me in 2023. The second episode featured Harvard professor Martin Kulldorff from Sweden. Martin has a summerhouse near Malmö and wrote he would like to meet with me. He came over, and I interviewed him in my home about what went wrong during the COVID-19 pandemic: *The harmful effects of lockdowns, facemask mandates, censorship, and scientific dishonesty*.[1719] The interview provides a good overview of all the failures our governments committed, apart from Sweden, which did not lock the society down and did not mandate the use of facemasks - yet had one of the lowest excess mortalities in the whole western world (see page 435).

Within 7 minutes after Janus had uploaded the interview on YouTube, it got this label: "COVID-19 vaccine. Learn about vaccine progress from the WHO." I did that and found out that some of WHO's information was questionable, which I explained in our newsletter.[1720] Strangely, within a couple of hours, YouTube removed the link to the WHO, with no explanation. Perhaps YouTube was worried about their reputation. I had interviewed one of the most knowledgeable people in the world who had partly contradicted WHO's advice.

Martin has explained that he was censored by Twitter, LinkedIn, Facebook, and YouTube for contravening official policy and he asked: "Who decided that American free-speech rights did not apply to honest scientific comments at odds with those of the CDC director?"[1721] He added: "When scientists have different takes on topics of public importance, universities

should organize open and civilized debates to pursue the truth. Harvard could have done that."

Our main focus is psychiatry because this specialty is second to none in harming people. Janus and I went on a 12-day tour to the USA in November 2023 I had arranged to interview 11 people and to London in April 2024 where I interviewed 4 people in relation to the annual meeting in the Critical Psychiatry Network.

Many of the people I interviewed on these tours and via the Internet have a deep insight into psychiatry: Mark Horowitz, Huey Freeman, Kim Witczak, Michael Baum, Jim Gottstein, Nancy Rubenstein, Wendy Dolin, John Read, Katinka Blackford Newman, Sami Timimi, and Joanna Moncrieff. We came home with over 20 hours of raw film in cinema quality and have uploaded some of the episodes, e.g. *Being abused by psychiatry, lies in court, and winning lawsuits to prevent forced drugging*, with Jim Gottstein, and *Why electroshock will likely become abandoned*, with John Read.

We have also uploaded short episodes where I explain why people should not take depression drugs or neuroleptics, and an interview with John Ioannidis, *Why did Cochrane expel Peter Gøtzsche?*, where we discuss what went wrong in Cochrane.

On our trip to the USA, we travelled 40,000 km, which is the circumference of the Earth, and came to Chicago, Minneapolis, Stanford, Portland, Los Angeles and Maui, but only carried hand luggage to avoid waiting for our bags.

I needed to learn how I could best fulfil my new role as a TV host and Janus told me that there are four main types of interviewees. One goes off a tangent that has nothing to do with the subject and needs to be stopped; one talks like a waterfall and also needs to be stopped; one talks very little and needs nursing and questioning; and one gives you no trouble. I met with all four types during our trip; a couple of them overlapped two of the four categories; and one interrupted me repeatedly in the middle of an explanation.

Janus and I created many ideas along the way, and he really got me working. I wrote this autobiography, an update of my mammography screening book[1722] and yet another psychiatry book[1723] that summarises and expands on what I had written about earlier. These books are freely available.

We did not know that our trip coincided with the Thanksgiving week, but there were no obstacles and the waiting time in security was surprisingly short, only about 5-15 minutes.

The rule that you must take off your shoes to have them X-rayed unless you are at least 75 years old is meaningless. As not all airports have it, it cannot be important, and there is no age limit for terrorism. I joked that demented people can be pretty violent and decided to play tricks on the security officers. I simply nodded or said yes when asked if I was 75, which was accepted.

When I was asked how old I was, I said I had birthday two days ago - which was correct - but couldn't remember my age, which I thought was 75 - one year too much. My dementia trick also went home, and I kept my shoes on.

The last time was in Chicago, on the way back to Copenhagen. "Your shoes," said the officer, to which I replied: "I am old. I have not taken my shoes off here in the USA." I was waved through.

Six metres further ahead, there was another officer who didn't say anything, but showed with his hands that I needed to take my shoes off. I said: "I am old and don't take my shoes off, as I already told your colleague over there." I was waved through.

Travelling has its challenges. In 1996, I was going to a meeting in Genève but couldn't find my passport. We had forgotten it was at the Australian embassy because my wife and I

had applied for a visa. During our desperate searches in the house on the day of my travel, we found an old passport belonging to my wife, which she had reported lost, so it was no longer valid. Well, I thought, a passport on Interpol's list of missing passports with my wife's photo is likely better than no passport. So, off I went and showed the passport to various people, both in Copenhagen and in Genève. To my big surprise, it was accepted everywhere, also when I left Genève even though people opened it where my wife's photo was.

This was lucky for me. In 1996, I had agreed with Professor Thorkild IA Sørensen that I would move my centre to his Institute for Disease Prevention and, to entice me to do this, he had ensured with the Director of the Copenhagen Hospital Corporation, Erik Juhl, that I would be appointed chief physician at the same time.

However, at the meeting in Genève about liver diseases we both attended, Thorkild suddenly told me during a lunch break that I should pay him for getting access to his data centre and statistician.

I didn't need any of this. Moreover, I had no guarantee that he could not raise the fee, e.g. if he came in financial trouble. I therefore cancelled the agreement and convinced Erik that my post as a chief physician should not be dependent on the arrangement. The post was announced, and I got it.

When I became professor of Clinical Research Design and Analysis in 2010 at the University of Copenhagen, it was also on my own initiative. I contacted the Dean, Ulla Wewer, and told her that my work was so important that it deserved a professorship. Next, I met with Vice Dean Birgitte Nauntofte who told me the university had also thought about this. So, a brand new professorship was created and I got it.

In 2003, when I arrived at the airport in Ottawa, I was so exhausted, tired, and irritable that when the customs officer asked me what my purpose was of coming to Canada, I thought, well, I can tell her just about anything, and it won't matter. So, I said - given my interest in photography when I was young - that I was attending a world conference in nude photography. When she stared at me in disbelief, I added: "I am the top model."

She exploded. She told me she could send me right back to Denmark. I replied that this would not be wise, as I had been invited by her government - slightly exaggerated, but the meeting had government funding.

I was sent to an office where some black people looking like drug traffickers were lying on benches. After half an hour, an officer asked me why I was there. I told him so and saw a faint smile on his face. "Welcome to Canada," he said. I was embarrassed to find out that a limousine had been waiting for me to drive me far away into the woods where the hotel was, Chateau Montebello.

## Email mysteries

When the postman came with our letters, no one censored them. But when I tried to find out why some of my emails get blocked, I entered an obscure world of gobbledygook.[1724]

I do not have a Google email but when I sent two tweets in an email, Google blocked me, "most likely due to presence of bit.ly links." Well, we all use abbreviated URLs because the original ones are too long for a 280-character tweet.

You cannot see which recipients that are blocked: "Your message could not be delivered to one or more recipients. It's attached below." It is never attached, despite this text. I was told to go to support.google.com for more information, which was more gobbledygook. A long life in research has taught me that IT people are second to none in confusing people.

I wrote to my colleagues: “There is no end to the absurdities and Big Tech censorship. When I sent the message below about Facebook censorship, Google censored it ... It is unbelievable. I recommend everyone with a gmail to get another mail host.”

But I found out that Google also censors messages that don’t go to people with a gmail. I thought I could circumvent Google’s censorship by removing the bit.ly part but then I got error messages from people who don’t use gmail. And when I am told my message was failed and I check it, people often write back that they got it anyhow.

Sometimes, I am told that my message was not delivered because it “contains a known spam email address.” I have never been able to work out *which* spam email address this was about. But sometimes my mails to over 100 other people on email lists we use every day get blocked because there are too many recipients, which is why Google suspects spam.

When I looked up what “in reply to EOD command” means on Google, I found a cry for help in Dutch about this. Someone replied that it means the email is rejected by a server, generally for security reasons. So, the spam email address was not in my message, as I was told it was. I was the spammer! This is double Dutch.

Gmail explains that they may block a message if “the sending IP has had a history of sending unsolicited messages.” Many people have no idea what IP means. In Denmark, it means disability pension. And what exactly constitutes an unsolicited message? And why may we not send messages if we are on an email list and enrich each other with our messages? Some people have been forced to ask others to email for them because they are *always* blocked.

Every time I write to a particular Canadian colleague, I am told that my message is delayed, “server temporarily unavailable.” This is the modern version of, “The postman gets bitten by a dog every time you write to this person, so he is temporarily unavailable.”

What I miss the most are explanations that are correct and which I can understand. If am stopped in the traffic, the police will tell me what I did wrong. If your emails are blocked, you don’t have a clue what your offence is. What a world we have created.

# 16 The Chinese virus: killed millions and scientific freedom

This was the title of a book I published in 2022.[1725] The COVID-19 pandemic led to the worst censorship I have ever seen, and harassment of people who disagreed with the official views became the norm. The censorship was highly unidirectional. Researchers critical of lock-downs and face masks were torpedoed, smeared and ridiculed.

Scientific rigour and ethical norms hit the bottom. Many of the new overnight experts dismissed evidence-based approaches like randomised trials, and the disdain for reliable research was sometimes even celebrated.[1726]

The pseudo experts were loved by the media. I wrote in a newspaper that after four years with Trump and one year with the same Danish "expert" on TV, Allan Randrup Thomsen, a laboratory researcher, who was always worried and uttered trifles virtually every day about the pandemic anyone could have said, I needed a new remote control because I had used the mute button so much that it had stopped working.[1727] When I asked a TV journalist why they always interviewed Thomsen, I was told that he was well prepared because he read what some journalists had written!

The anti-vaxxer label was sprinkled on everyone who dared write critically about anything, e.g. when psychiatrist Michael P Hengartner pointed out that the effect of depression pills is poor and of questionable clinical significance, and when investigative journalist Paul D Thacker he reported on Monsanto's lies about the lack of toxicity of glyphosate (Roundup). Monsanto behaved in a gangster-like fashion to protect their income.[1728]

The big industries - pharma, tobacco, chemical, fossil fuels, and agriculture - often use the same PR companies, e.g. the giant Burson-Marsteller. If you question their lies, you may be labelled anti-science, anti-vaxxer, anti-psychiatry, a conspiracist, a pill-shamer, or worse.

Dictators use the same strategy. If you criticise them, you are anti-government, an enemy of the state, or a national security risk, which is an excuse for locking you up or make you disappear, the euphemism for state organised murder.

As a child, I collected stamps. Perhaps I should have collected labels, too. I have been accused of having blood on my hands when I showed that some drugs are dangerous and should be avoided (many times); not loving women when I showed that mammography screening doesn't work and is harmful; being a statistical masturbist;[1729] risking "the lives of millions of women;"[1730] being a flat Earth advocate (many times); and being anti-psychiatry or an anti-vaxxer (many times).

## The destructive influence of social media and major science journals

In April 2021, the UK parliament asked Twitter and Facebook representatives to explain their firms' censorship of discussion around COVID-19.[1731] Two particularly pertinent cases were raised: A tweet by Martin Kulldorff and a statement on Facebook by Carl Heneghan.

Someone wrote to Martin on 16 March 2021 that it seems to be a religious mantra now that everyone MUST be vaccinated. Martin replied, "No. Thinking that everyone must be vaccinated is as scientifically flawed as thinking that nobody should. Covid vaccines are important for older high-risk people, and their caretakers. Those with prior natural infection do not need it. Nor children."

Martin's tweet was measured, informative, and in accordance with the science, but it was labelled "misleading" by Twitter. Tweeters were rendered unable to interact with it and

were instructed that "health officials recommend a vaccine for most people." This was absurd to say, as Martin had not contradicted it.

Some people called Carl "anti-science" for daring to convey the results of the randomised trials of face masks.[1732] He and Tom Jefferson had noted that there was a troubling lack of robust evidence that they worked and that, despite being a subject of global importance, there had been a total lack of interest from governments in pursuing evidence-based medicine in this area. They also noted that the only studies that had shown face masks to be effective at stopping airborne diseases had been observational, which are prone to bias.

Carl posted a link on Facebook to an article he had written about the Danish trial of face masks that failed to find an effect,[1733] and Facebook immediately labelled the article "False information. Checked by independent fact-checkers." As Carl noted, nothing in his article was "false."

Martin, Carl and Tom are dissenting scientists who hold positions at esteemed institutions. So, on what basis could Twitter and Facebook declare their arguments void? The answers provided to the British parliamentarians were chilling. Someone linked to a video in a tweet with the appropriate handle @BigBrotherWatch:[1734]

Parliamentarian: "Who in your organisation would have been cited … and been qualified … that a professor of medicine was wrong?"

Katy Minshall, head of UK public policy at Twitter: "Well, it is not Twitter saying he is wrong or misleading, it is the CDC and health authorities around the world, and with that tweet you are referring to, my understanding is that it said, if you have had COVID-19 before, you have natural immunity and you don't need the vaccine. That's different to what the CDC and other health authorities around the world have said, which is that vaccines are effective in most people. What we want to do is that, when people see that tweet, to really quickly direct them to authoritative sources of information like the CDC or the NHS or the Department of Health, so they can see what the official guidance is and make up their own mind."

Parliamentarian: "On these issues, some of these highly controversial, really, current issues around public health, you think there is a danger in having debate amongst acknowledged experts, and that it is far better that everybody just sees the official public health position, even though that of course in time may change."

Minshall: "I think that's a good question … because you are right, on the one hand, the information environment and what's accurate with regard to the pandemic is evolving with the government providing different and sometimes competing advice …"

Minshall essentially said that anything that contradicts official guidance from public health authorities is deemed misleading by Twitter. She made the mistake that philosopher Arthur Schopenhauer in his book *The Art of Always Being Right* called "Appeal to authority rather than reason," which is the antithesis of science.

Censorship with appeal to authorities is poison for our democracies. To call CDC an authoritative source is a bad joke (see page 292). Moreover, official advice has often been proven wrong and authorities often disagree, e.g. in their advice about vaccines. Another issue that makes fact checking close to impossible is that most science cannot be trusted.

Censorship is also influenced by social norms. Did social media ever call religious utterings false or misleading? Many people believe in gods, even though it is extremely unlikely that they exist.[1735] All social media have American owners, and it is a social norm in the US to be religious. When most citizens in a country share a god delusion, it is not likely to be labelled "false" by people who share the same delusion.

To censor people who have other ideas than those propagated by the regime is the modern version of the book burnings in Nazi Germany and Austria in the 1930s.

Big Tech censorship has turned a few owners of private companies into non-elected rulers. They are both the lawmakers, the moral police, and the judges in relation to our freedom of speech. This characterises a dictatorship. A researcher wrote in an email: The moment we let some young adults in Facebook decide what is true or false, we are doomed.

In this Orwellian world, minority opinions are labelled disinformation by robotic algorithms. Big Robot is watching you. I have had episodes on YouTube removed faster than any human being would have had time to see them.

Everyone should read George Orwell's masterpiece, *1984*, which is more relevant than ever. His other masterpiece, *Animal Farm*, shows what happens if we give our leaders too much power. We have given too much power to social media.

One of my Cochrane employees, Dina Muscat Meng, persuaded me to open a Twitter account because I was often in the media. I have 35,000 followers and got nervous when in June 2021, Twitter wrote to me. A German had reported me for this tweet: "Made in China: the coronavirus that killed millions of people was likely fabricated on purpose to make it dangerous to humans as part of the gain-of-function research and escaped from the Wuhan Institute of Virology because of sloppy safety procedures."[1736]

Twitter found that my tweet should not be removed. I was convinced that if the content of the article I had written[1737] and tweeted about, was posted on Facebook or YouTube, it would be taken down even though I had carefully described how the false narrative about a natural origin of the virus started and had noted, with examples, that dangerous viruses sometimes escape from labs.

Why do social media accept anonymous complaints? In common law, this is only allowed to protect endangered complainants, e.g. in trials involving violent, organised crime. Complainants often have axes to grind, and it is therefore necessary to know who they are to reduce the risk of abuse, and to expose them publicly of wrongdoing, if necessary.

Facebook tried to buy Twitter but, luckily, the deal didn't get through. Twitter has also behaved badly. In the autumn of 2021, it removed Juan Gérvas's account after he had alerted people to an article that reported on three suicides, one suicide attempt and one case of aggression in close relation to starting hydroxychloroquine for COVID-19. Twitter's censorship was meaningless. The US package insert for hydroxychloroquine lists under Warnings: "Neuropsychiatric events, including suicidality." Under adverse events is listed: "Psychiatric disorders: Affect/emotional lability, nervousness, irritability, nightmares, psychosis, suicidal behavior." It took three months for Twitter to recognise their mistake, apologise and reinstate Juan's account.

Should there be censorship on social media? That is not an easy question.[1738] But it disturbs me when Telegram, founded by two Russian brothers, spreads child pornography, ISIS propaganda, information from neo-Nazis, fascist hate groups and white supremacists. Other social media are full of messages from terrorist organisations and conspiracy theorists such as QAnon.

The cover-up of the origin of the COVID-19 pandemic, which started immediately, when the pandemic broke out in December 2019, is the worst in medical history.[1739] *All* key persons and top officials lied, both in China and the USA, and many people, including editors of prestigious science journals, deserved to be called "Beijing's useful idiots."[1740]

For over three years, China got away with their lies, censorship and obfuscations. They shaped the public opinion that the virus had a natural origin and had spread from animals to humans, even though not a single thread of evidence in support of this was ever produced.

But in 2023, China's defences started cracking[1741] when the first three people infected by the virus, who were all admitted to hospital, had been named.[1742] They worked in the lab where they did gain-of-function experiments - whose purpose is to make harmless viruses deadly - and were in their thirties and forties.[1743] It wasn't influenza, as such people don't get very sick with influenza, and one of the researchers' family members died.

When the Wuhan Institute put out their first paper about the pandemic virus (SARS-CoV-2), they failed to point out the novel furin cleavage site although they inserted it in SARS-like viruses in their lab to make them more deadly. A molecular biologist from Harvard dryly remarked that, "It's as if these scientists proposed putting horns on horses, but when a unicorn shows up in their city a year later, they write a paper describing every part of it except its horn."[1744] It was also revealed that US top scientists lied profusely to Congress during a hearing in 2023, including about the concerns they had in early 2020 that the pandemic seemed to have been caused by a lab leak of a virus manufactured with financial support from the US NIH.

An investigation published in 2023 showed that the Chinese military funded the gain-of-function research.[1745] The purpose was to produce bioweapons, and a book published in 2015 by the military academy discusses how SARS viruses represent a "new era of genetic weapons" that can be "artificially manipulated into an emerging human disease virus, then weaponised and unleashed." Clearly, if a country could vaccinate its population against its own secret and deadly virus, it might have a weapon to shift the balance of world power. It was like a James Bond movie, but this time for real.

What we know for sure is that if the Chinese has not conducted reckless experiments in Wuhan ignoring the obligatory safety precautions, there would have been no pandemic. It is deeply concerning that the WHO and our governments have not called for a ban on this highly dangerous playing with fire research that hasn't led to anything of use but to the death of, well, we don't know exactly, but millions of people.

It was not China, but Taiwan that alerted the WHO to the risk of the new virus, but the WHO did not pass on the concern to other countries.[1746] The WHO praised China's handling of the coronavirus outbreak even though China covered it up. Without any evidence, Chinese authorities blamed a seafood market, although the first documented cases of COVID-19 involved people who had never been there.

It is extremely likely that it was a lab leak in Wuhan and that the virus was "Made in China."[1747] But those who knew did not tell us what they knew, and the darkest moment in science in my lifetime happened two months into the pandemic when virologists and others published a *Lancet* letter,[1748] which derailed the debate. After this, the obligatory narrative was that the pandemic had a natural origin and was not due to a lab leak.

Jamie Metzl, from WHO's advisory committee on human genome editing, said it was "Scientific propaganda and a form of thuggery and intimidation. By labeling anyone with different views a conspiracy theorist, the *Lancet* letter was the worst form of bullying in full contravention of the scientific method."[1749]

It is appalling that scientists called the most plausible hypothesis rumours, misinformation, and conspiracy theories. Peter Daszak, a British zoologist working in the USA, secretly organised and drafted the *Lancet* letter. It stated the authors had no conflicts of interest,

which wasn't true. If it was revealed that the virus had escaped from research Daszak funded, he would be potentially culpable.

Daszak ignored Congressional requests to clarify central issues, and he lied about many things, e.g. he claimed the Wuhan Institute had never kept live bats. Just before the pandemic outbreak, Daszak talked in glowing terms of how his researchers at the Wuhan Institute had created over 100 new SARS-related coronaviruses.[1750] But when he heard of the outbreak in Wuhan, he didn't provide health authorities with the plentiful information at his disposal but immediately launched a public relations campaign to persuade the world that the epidemic couldn't possibly have been caused by one of his manufactured viruses.

Of all known SARS-related beta-coronaviruses, only SARS-CoV-2 has a furin cleavage site, and it is virtually impossible that this could have happened via mutations.[1751] A sure way to make a virus deadlier is to give it a furin cleavage site, which the Chinese researchers did in at least 11 gain-of-function experiments.[1752]

One month after the *Lancet* letter, a group of virologists led by Kristian G Andersen published a misleading letter in *Nature Medicine* declaring that, "Our analyses clearly show that SARS-CoV-2 is not a laboratory construct or a purposefully manipulated virus."[1753] Their analyses didn't show anything. And their conclusion didn't follow from their premises.

A year later, 14 scientists asked *Lancet* to reopen the debate about the pandemic's origin, but *Lancet* rejected the letter saying it was "not a priority."[1754] They appealed, but their letter was evaluated by a special committee whose head was Daszak! The letter, published on a website,[1755] documented that Andersen's arguments were logically flawed.

Andersen was highly active on social media condemning the lab leak theory and confronting its proponents, and he wrote that any type of lab origin would have to involve a massive conspiracy. Facebook never censored any of Andersen's blatant misinformation. Instead, Facebook routinely censored articles exploring the lab leak theory, labelling them "false information" and punished news publishers by limiting their reach on the platform.

Just before Andersen published his letter in *Nature Medicine*, he had admitted to US presidential advisor Anthony Fauci that the virus looked engineered and inconsistent with expectations from evolutionary theory. Thus, it is fair to call his letter mendacious.[1756]

In 2023, Andersen explained to Congress that his sudden change in belief in early February 2020 was based on "many factors, including additional data, analyses, learning more about coronaviruses, and discussions with colleagues and collaborators."[1757] This was also a huge lie. Fauci visited CIA headquarters secretly and seven CIA analysts received performance bonuses after changing a report to downplay concerns about a possible lab origin.

Fauci propagated lies about the likely origin of the virus and what the US funding of the laboratory in Wuhan was about.[1758] He claimed multiple times at a Senate hearing that the NIH had never funded gain-of-function research in Wuhan.[1759] His lie could not have been bigger. The NIH was in the terrible position of having funded experiments that had caused the death of about a million Americans, and its Director Francis Collins also lied.

Our most prestigious medical journals continued to publish plain nonsense. Angela L Rasmussen wrote in *Nature Medicine* that the lab leak theory was a "complex international conspiracy involving Bill Gates, the Chinese Communist Party and 5G wireless network infrastructure with an end goal of ushering in a new world order."[1760] Perhaps she had seen too many James Bond movies.

*Nature* protected China to an unbelievable extent. They did not want to publish anything suggesting the pandemic could have been caused by a lab leak of an engineered virus, and what they had published in the past that hinted at this, they covered with a statement at

the top saying that such papers were being used as a "basis for unverified theories that the novel coronavirus causing COVID-19 was engineered,"[1761] adding that "there is no evidence that this is true; scientists believe that an animal is the most likely source of the coronavirus." It is unheard of that a top scientific journal attaches labels about what scientists "believe" in relation to previously published papers.

*Nature* also committed editorial misconduct.[1762] When the Chinese gave up on the idea that the virus came from animals sold at the Huanan Seafood Market, they turned to pangolins and submitted four manuscripts describing a pangolin coronavirus with a similar spike receptor-binding domain to SARS-CoV-2, all relying heavily on data published by one group of Chinese scientists. Two of the papers were published by *Nature*, but it turned out that the pangolin link was a false trail laid out by China. *Nature*, however, rejected a submission from a scientist who showed that all four papers primarily used samples from the same batch of pangolins and that key data were inaccurately reported.

Daszak's closest collaborator in China, Shi Zhengli, omitted important data in publications and when people asked for virus samples, Daszak said they had disintegrated. The termites ate my data, as an Indian researcher once said when he had something to hide.

I explain in my book that there are good reasons to suspect that the major journals wanted to appease China for commercial reasons - total corruption of science. Richard Horton, *Lancet's* editor, has a bad habit of defending the wrong people, which include Andrew Wakefield and Paolo Macchiarini.[1763] He is also a staunch defender of Daszak and tweeted, on 9 June 2020: "Peter Daszak rejects conspiracy theories about the origins of COVID-19: and he knows more than most of us about corona-viruses."[1764] In September 2020, *Lancet* appointed Daszak as chair of *The Lancet Covid-19 Commission* set up to "analyse the available evidence for each of the hypotheses put forward on the origins of COVID-19." A bullet proof arrangement ensuring nothing unwelcome would emerge.

*Lancet* enjoys a close relationship with China's medical establishment.[1765] In 2008, Horton was honoured at The Great Hall of the People in Beijing's Tiananmen Square - where the People's Liberation Army liberated hundreds or thousands of peaceful protesters in 1989 by murdering them. This was to mark an "unprecedented" collaboration between Peking University and *Lancet*, and in 2010, *Lancet* established an office in Beijing.

In 2015, Horton received the Friendship Award from the Government of China - the highest honour awarded to foreign experts. He told his readers about "China's emphasis on friendship, and the free flow of critical ideas."[1766] It is difficult to provide a more misleading statement than this about how China operates. When *Lancet* rejected my letter where I called on the WHO and the United Nations to issue a call to stop all gain-of-function research permanently, I published it on my website.[1767]

*Science Magazine* was also one of Beijing's useful idiots. They were overly friendly with Daszak and forgot what they had learned about critical journalism.[1768] Already in February 2020, *Science* reported that scientists "strongly condemn" rumours and conspiracy theories about the origin of the pandemic.[1769] If you have no arguments, you raise your voice. Daszak said that "We're in the midst of the social media misinformation age." Indeed, but he forgot to say he was the main driver of it.

*Science* did not cover the amazing revelations when, in October 2021, Congress investigators revealed that the NIH had terminated its grant to Daszak after he had lied about what the funds were used for. Instead, a month later, *Science* published an almost 5,000-word article that glorified him.[1770] *Science's* editor, Holden Thorp, celebrated it in a tweet: "This is riveting piece and also an excellent summary of the scientific issues. Going to make the lab

leak crowd pretty jumpy." This is not the type of remark you expect from the editor of one of the world's most prestigious scientific journals. Daszak appeared on the front page with the title of the article: *Prophet in purgatory: Peter Daszak is fighting accusations that his work on the pandemic prevention helped spark COVID-19*.

*Science* published this when the death toll was about 6 million, and when it had been revealed that Daszak, rather than being a scientist working on preventing pandemics, had created one, which he had covered up for two years.

In December 2021, *Science* published an article by Michael Worobey who said he would elucidate the origin of the pandemic.[1771] He didn't, and his article was so China apologetic that it might as well have been written by the Chinese Communist Party. His idea that the origin was in the animal market had been discarded in many, much better papers long ago.

Worobey credited high-standing Chinese officials for having detected the new disease, which is an inexcusable lie. It was detected by Chinese doctor Li Wenliang whom the Chinese authorities harassed tremendously. Worobey did not mention that the closest relative to the virus was 1500 km away; that despite analysing 80,000 animals, no intermediate host had been found; that the virus genome is not a natural one; that it is not even certain that SARS-CoV-2 ever infected a bat (the virus has a weak affinity to bat cells); or that the Chinese government blocked any independent research. He mentioned WHO's inspection in Wuhan but did not utter a single critical word about this farce (see page 452).

Kristian G Andersen didn't give up either. In 2024, he published a study in *Cell* claiming that the pandemic originated in the animal market, and Worobey said: "It's far beyond reasonable doubt that that this is how it happened", and that other explanations for the data required "really quite fanciful absurd scenarios."[1772] However, they didn't show that any of the animals had been infected, and they could simply have been carriers of a virus that people from the lab had transmitted to them.

*Scientific American* is also one of Beijing's useful idiots. In June 2020, they praised Shi Zhengli[1773] who is similarly mendacious as Daszak. A year later, she denied that her lab was ever involved in gain-of-function experiments that enhance a virus's virulence! When, in March 2021, Robert Redfield told CNN that it was most likely that the pandemic came from a laboratory, *Scientific American's* editor, Laura Helmuth, tweeted that "former CDC director Robert Redfield shared the conspiracy theory that the virus came from the Wuhan lab."

The punishment of those who were honest was harsh. A survey of over 300 scientists who had given media interviews found that 15% had received death threats.[1774]

*Scientific American* is owned by *Nature*, owned by Springer. This magazine has a deplorable record in poor publication ethics that threatens scientific freedom. I mention in my book how they covered up for Israeli war crimes and shall provide another telling example in the section about lockdowns below involving three people whom I know personally.

The US media were disgraceful microphone holders that didn't question anything and they also lied. In April 2020, three former CIA Deputy Directors stated in an article that they didn't know where the virus came from. A month later, James Gorman, a science writer for *New York Times*, wrote that, "Virologists and intelligence agencies agree that the virus evolved in nature and spread from animals to humans."[1775] It was likely the worst newspaper to swallow everything people with huge conflicts of interest told them. In May 2020, they depicted the Wuhan Institute of Virology as a victim of "conspiracy theories" while *Nature* called the lab leak hypothesis "coronavirus misinformation" and "false information."[1776] In December 2020, an Associated Press investigation found documents from

March 2020 showing how Beijing had shaped and censored research into the origins of SARS-CoV-2.

*New York Times* has a lot to respond for.[1777] They printed China's mortality numbers as fact without questioning them, even though COVID-19 deaths increased by only two people during six months from August 2020 to February 2021. When I looked up worldometers.info in February 2022, the number of deaths was still 4,636, the same as a year earlier. China claimed three COVID-19 deaths per million inhabitants, the same as Burundi. Officially, these two countries had the lowest number of deaths out of the 226 listed nations. You don't need to be a Sherlock Holmes to see through this. In its first report on the pandemic, on 17 February 2020, the *New York Times* called lab leak a "fringe theory," and its reporter called it "the kind of conspiracy once reserved for the tinfoil hatters" on Twitter.

The *Times* let Daszak publish total rubbish, e.g. that the pandemic was caused by "road-building, deforestation, land clearing and agricultural development," and they used him as a key source in over a dozen articles without ever mentioning that his organisation funded the dangerous research in Wuhan. They took millions of dollars from Chinese propaganda outlets such as *China Daily* and published hundreds of their "advertorials." The *Times* has lost our trust forever. It is so sad. Nothing left you can trust in American legacy media.

The pandemic could be shortened to panic.[1778] It was also a pandemic of censorship and poor science. The authorities didn't heed the researchers' knowledge, the researchers didn't embark on studies we badly needed, and if randomised trials didn't tell the authorities what they wanted to hear, they based their decisions on flawed observational studies instead.

## The folly of lockdowns

The restrictions to ordinary life made little sense. The lockdowns went counter to what we know about respiratory viruses, that it is impossible to lock them out, and they caused a lot of collateral damage, including an increase in deaths from other causes than COVID-19. Jonas Ludvigsson published a ground-breaking Swedish study showing it is safe to keep schools open,[1779] but this was taboo. After he had been harassed, he preferred to stay quiet.

Stefan Baral from the Johns Hopkins Center for Global Health was unable to publish a letter about the harms of lockdowns, which was rejected by more than 10 scientific journals and 6 newspapers, sometimes with the pretence that there was nothing useful in it.[1780] It was the first time in his career that he could not get a piece placed anywhere.

Journalists Jeanne Lenzer and Shannon Brownlee described in *Scientific American* how John Ioannidis from Stanford University became the subject of a horrible witch-hunt, which included obscene and defamatory emails sent to his administrators and colleagues at Stanford.[1781] In March 2020, John had expressed concerns that we lacked data on the benefits and harms of lockdowns and other draconian responses to the pandemic.[1782] The coronavirus might be less dangerous than assumed and overzealous lockdowns to prevent its spread could pose a greater risk than the virus. A video with him was viewed by over half a million people before YouTube took it down, saying it was misinformation.

Next, *Scientific American* committed editorial misconduct.[1783] The editors uploaded "corrections" to the article by Lenzer and Brownlee, several of which were of their own errors, and some were untrue or irrelevant. When Lenzer and Brownlee tried to correct the false corrections, the editors denied them this opportunity. The false corrections triggered an out-pouring of hate mail and false claims about John and the integrity of Lenzer and Brownlee as journalists. Jeffrey S Flier, former dean at Harvard Medical School, wrote that

"By bowing to the mob that has been attacking Ioannidis with false accusations that distort the totality of his work, *Scientific American* has lent support to behaviors that violate the norms of ethical scientific conduct."

As misconduct should always be exposed, I gave an account of the affair on my website[1784] and in my vaccine book, and Lenzer published Flier's letter and her and Brownlee's corrections on her website.[1785]

In May 2020, I argued that the Danish lockdown was unnecessary.[1786] Despite widely different lockdown policies in different countries, the reductions in mortality had been remarkably similar.[1787] I warned that, despite a higher mortality rate in Sweden, it was much too early to conclude if their policy of avoiding lockdown was good or bad. I also noted that we had not had any public discussions about if we could do better, and on TV, everyone spoke with the same voice, not questioning anything the government said, just like in China.

In September 2020, Michael Head - whose deplorable role in the HPV debacle I commented on earlier (see page 287) - sent an email to Susan Mitchie, a member of a group that advised the UK government about the pandemic, which she forwarded to other group members.[1788] Four days earlier, Carl Heneghan from the Centre for Evidence-based Medicine in Oxford and other scientists had briefed Prime Minister Boris Johnson and had argued for more targeted measures to protect the vulnerable rather than having a blanket lockdown.

In a newspaper article,[1789] Head's email was condemned by former Supreme Court judge Lord Sumption who called it an example of scientists being hounded by those who could not counter their arguments. The people singled out in Head's email were Carl Heneghan, Tom Jefferson, and me, because we had all spoken out about the harms of lockdowns.

Maliciously, Head did not discuss the science but called Tom and me "anti-vaccine activists" and noted that Carl's work "is of great interest and use to the anti-vax community." Carl noted they had carried out a review on the impact of lockdown on vital childhood vaccines, which showed the catastrophic effect of the restrictions on the mass implementation of vaccines like those for MMR (measles, mumps, and rubella).

I noted that to label me as an "anti-vaccine activist" took me back to medieval times: "In science you need open debate to further scientific understanding. During the Covid-19 epidemic the debate has many times been the opposite, with only one truth, like a religious dogma … We acknowledge many of our vaccines have been of great benefit and saved millions of lives and I certainly hope the COVID-19 vaccine will save millions of lives as well. People … have been furthering their own agenda in all ways, and this involves below the belt punches … they show that academically they have lost the argument."

In December 2020, I challenged an analysis of the COVID-19 fatality risk,[1790] which the authors claimed was about 10 times larger than for influenza. They reported a fatality rate of 0.8% in Spain and quoted an unpublished review that found 0.68%. They also quoted a review by John Ioannidis published online in the *Bulletin of the World Health Organization* but did not say what he found. He included 61 studies and 8 preliminary national estimates, and the median fatality rate was only 0.27%. It was dishonest not to mention this lower rate that came from a much better study. I noted that fatality rates depend on the infectious dose, which is higher in settings with overcrowding. We can therefore only estimate them approximately. In outbreaks of measles, a commonly used estimate is 0.2%, but when measles hit a nonimmune population in the Faroe Islands in 1846, 78% were attacked and the case fatality rate was 2.8%,[1791] over 10 times higher than the usual rate. I also noted that the median case fatality rate was about 1% in a systematic review of laboratory confirmed influenza during the mild influenza pandemic in 2009 and the following years, and that the

infection fatality rate for COVID-19 was only 0.16% in Denmark when blood donors were tested for coronavirus antibodies.

Given the many deaths, it was difficult for people to understand that the fatality rate for COVID-19 is similar to that for seasonal influenza. SARS-CoV-2 has many similarities to the influenza virus in terms of size of the virus and infectivity, and the main reason why SARS-CoV-2 killed so many people is that there was no immunity in the population.

The Spaniards claimed that their result supported existing measures such as lockdowns and wearing face masks. It didn't and I noted that we had never introduced these drastic measures during influenza pandemics: "We cannot live with them for years to come. The World Bank has just estimated that the corona pandemic has caused an increase of about 100 million people living in extreme poverty. This is not because of COVID-19. It is because of the draconian measures we have introduced. We need a better strategy."

John and I agreed on these issues, but he suffered greatly for doing what he always does: follow the data.[1792] Nothing mattered. It didn't matter that the CDC confirmed what John had published, or that the WHO published his systematic review, which confirmed his findings that the infection fatality rate was much lower than what had been claimed. Numerous false claims were advanced in the press, including a charge that he had a financial conflict of interest related to a study he co-authored.

John argued that governments should protect the sick and elderly from infection while keeping businesses and schools open for the less vulnerable instead of destroying the world. Evil emails were sent to Stanford email accounts, and someone started a rumour online that John's 86-year-old mother had died of COVID-19. When friends began calling her apartment in Athens to ask about the funeral, she suffered a life-threatening hypertensive episode.

I disagreed with John's co-director, Steven Goodman, who argued that the rules for scientific debates are different when conducted in public. In an open society, the rules should be the same, and many lay people are able to follow the arguments and should not be denied the possibility of making up their own minds.

In February 2021, I commented[1793] on John's new study, which was the best so far about lockdowns,[1794] and demanded to get our lives back. They had used data 10 countries, which included all the individual US states and all the counties in Sweden, and they compared large lockdowns with small ones where schools and restaurants were kept open. They could not find any effect of large lockdowns even though their methods were sophisticated. I noted that those who die from the virus were 82 years old, on average, and that - if we assume lockdowns have any effect - it would cost 8 million Euros to prolong the life of one person. The Danish government didn't care. Already one year into the pandemic, it had left a bill of around 13,000 Euros to every Danish taxpayer and it would become much higher.

A year later, I pleaded again for a little sanity.[1795] We now had the omicron variant, which likely corresponded to a relatively mild influenza strain. So why were there still closed restaurants, semi-empty airports, and mandatory use of face masks? And why did Denmark have a world record in testing mania, testing tested 12 times as much as Sweden? Every Dane was tested 22 times, on average. It was total madness. People filled the streets in queues in front of the test centres. I humbly asked: "Will the follies ever stop?" I wish this stupidity would never be forgotten, but it was, and in 2025, the government praised itself for how wonderful they had been during the pandemic.

Many countries ran a zigzag course between closing and opening the society. In Norway, researchers attempted to do a study, but the government was unwilling to keep schools

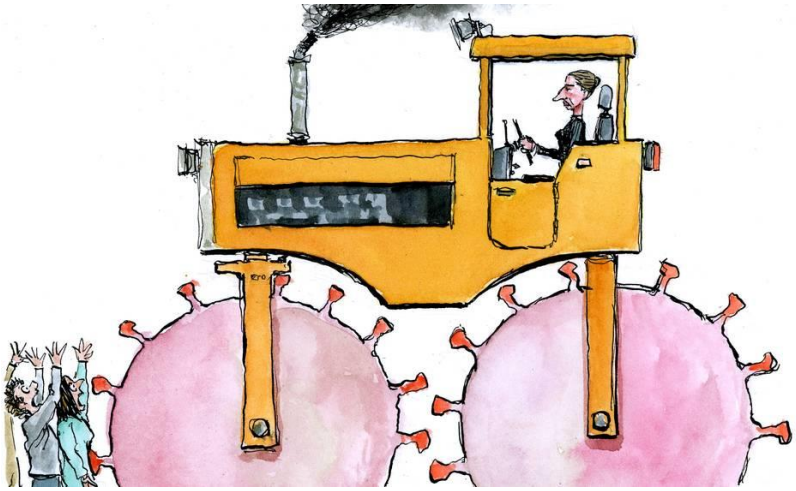
open.[1796] Two months later, when the virus waned, they refused to keep schools closed. But Norwegian TV shot the messenger: "Crazy researcher wants to experiment with children." It had no importance for policy making that a systematic review from April 2020 found that school closures did not contribute to the control of the SARS epidemic in China, Hong Kong, and Singapore.[1797] In America, they surely knew how to prioritise. In many large American cities, bars were open while schools were closed!

In Denmark, we closed our borders with Germany and Sweden when we had more coronavirus than they had. You were allowed to walk on a golf course, but only if you didn't play golf. I was forbidden to play badminton but not forbidden to play tennis. Football matches were allowed, if there were only 5 players on each team and no spectators. In Italy, people borrowed the neighbour's dog to get a little fresh air because it was allowed to walk the dog. And I could not send one of my books to a colleague in Brazil because the post office blocked it. I joked that soon, our prime minister would only allow one person at a time in double beds.[1798] Suddenly, a Friday afternoon, the government declared that only 10 and not 50 persons were allowed at gatherings from Monday onwards, which must have been a disaster for families and restaurants, e.g. if they had planned a birthday party.[1799] Many countries used the police or the military to ensure that people obeyed orders.

The Danish government dismissed basic human rights and created a nanny state where the frail elderly were forced to choose only one family member to visit them,[1800] even though many were more afraid of loneliness than of dying.

In some countries, people in nursing homes were imprisoned, not being allowed visitors for almost two years. Ethically, this unsolicited paternalism is unacceptable, and it subverts our democracies when the state knows best and violates basic human rights. History has shown that leaders who assure us that the situation is so grave that we must give up our freedom or ethical principles, or both, to gain security against an external or internal danger usually end up giving us neither freedom nor security, but absolute power to themselves.

In Denmark, it came so far that the Head of Cabinet, Per Okkels, wrote to the director of the Board of Health, Søren Brostrøm, that he should abandon his professionalism for political reasons. I warned that when truth doesn't matter, we are on our way to a dictatorship state. The evidence, or more often, the lack of evidence, was not discussed.



The Danish Prime Minister, Mette Frederiksen, at the steering wheel
Courtesy of Jyllands-Posten, cartoon by Rasmus Sand-Høyer

Politicians will not get in trouble for measures that are too draconian, only if it can be argued they did too little. The worst mistake was that all governments, apart from Sweden, ignored the fact that a respiratory virus cannot be contained by lockdowns. I was intensely frustrated to be a victim of our government's many follies.

The Great Barrington Declaration, published by Martin Kulldorff, Sunetra Gupta and Jay Bhattacharya in October 2020,[1801] emphasises the devastating effects of lockdowns, with the underprivileged disproportionately harmed. Arguing that for children, COVID-19 is less dangerous than influenza, it suggests that those at minimal risk of death should live their lives normally to build up immunity to the virus through natural infection and to establish herd immunity in the society. It recommends Focused Protection of the vulnerable, particularly in nursing homes, while schools, universities, sports facilities, restaurants, cultural activities, and other businesses should be open. Young low-risk adults should work normally, rather than from home. I did not find anything that was factually wrong, and the declaration received almost one million signatures, including mine.

Ten days later, the John Snow Memorandum was published in *The Lancet*.[1802] It is seriously manipulative, fearmongering and cherry-picking, with factual inaccuracies and references to highly unreliable science, e.g. modelling studies. It claims, with no references, that transmission of the virus can be mitigated by face masks, which is wrong.

The two declarations did not elicit enlightened debates, but acrimonious exchanges of views on social media and email lists dominated by strong emotions and no facts. The vitriolic attacks were almost exclusively directed against the Great Barrington Declaration, and they were orchestrated from the top. Francis Collins, the director of the NIH, wrote to Anthony Fauci: "This proposal from the three fringe epidemiologists who met with the Secretary [Minister of Health] seems to be getting a lot of attention – and even a co-signature from Nobel Prize winner Mike Leavitt at Stanford. There needs to be a quick and devastating published take down of its premises. I don't see anything like that online yet – is it underway?[1803] To ask for a little freedom was almost like being an enemy of the state.

The monomaniacal focus on the virus meant that many people with other diseases died. Many emergency visits disappeared, and many patients with heart attacks and ischaemic strokes didn't turn up at hospitals, likely because they were afraid of getting infected.[1804] Many businesses went bankrupt, millions lost their jobs, mental health deteriorated, and domestic violence increased because people were told to work from home.

Public trust was undermined when the various assertions were proven wrong. The draconian measures were introduced in a shroud of secrecy, and when journalists asked what the scientific basis was for them, they got no reply. Academic bullying and *ad hominem* attacks caused serious reputational harm and led some scientists to self-censor and avoid publishing data that could potentially reduce death rates.[1805]

After two years of lockdowns, governments around the world suddenly dismantled them in silence. From one day to another, the whole thing was supposed to be forgotten.

Sweden seems to be the only country where the politicians had the best possible advisors and respected their advice. COVID-19 mortality is the wrong outcome, as it is biased. We need to look at total mortality. Sweden did not lock down and did not mandate face masks - yet did exceptionally well. Numerous studies have shown that Sweden's excess mortality (total mortality during the pandemic compared to the years before the pandemic) was among the lowest in Europe during the pandemic and in several analyses, Sweden was

best.[1806] This is remarkable, also considering that Sweden did too little to protect people living in nursing homes in the beginning, which increased mortality.

This should ring alarm bells everywhere, but what we saw was pathetic defences of grossly failed policies to save face. The media were remarkably silent about the Swedish success as it exposed their own failures when they supported every draconian whim the politicians introduced without any critical thought.

As an example, the starting position for the official UK COVID-19 inquiry was that lockdowns and face masks were necessary and effective,[1807] and they were eager to dismiss the evidence that told us otherwise. In contrast, UK Prime Minister Rishi Sunak pointed to a peer-reviewed report that found that no matter which assumptions were used, the costs of lockdown exceed the benefits. The inquiry uncritically accepted substandard research and substandard advisors while bullying Carl Heneghan using provocative language to suggest he didn't have any expertise. Earlier, the Chief Scientific Adviser, Dame Angela McLean, had called Carl a "fuckwit" on a WhatsApp chat during a government meeting for his dissenting views on lockdowns.

The rulers' arrogance was extreme. In Orwell's novel *1984*, the Ministry of Truth is always right, like in *BBC's Yes, Minister* farce. In Italy, an inquiry will establish if the government's policies agreed with WHO's advice. Surely, there will be no unwelcome surprises.

I have argued why all knowledgeable people need to speak up.[1808] Those who hold the power have not learned anything from their mistakes and will repeat them next time a pandemic haunts the globe. They will again lock down and mandate whole populations to look like bank robbers. We need to establish an international cooperation of scientists at the highest level who will stand together and never again accept to be silenced when a pandemic hits us. The scientists should be involved right from the start, and everything politicians would like to do should be tested in randomised trials, if we don't know if it causes more good than harm. As we tested virtually nothing during the COVID-19 pandemic, we learned very little.[1809]

In 2024, we received the very disturbing news that Professor Martin Kulldorff was fired from Harvard University.[1810] Martin did all the right things during the COVID-19 hysteria, but Harvard fired him for being honest, which was disgraceful, unacademic and went against Harvard's key principle: *Veritas*. His own account of what happened, "Harvard tramples the truth," [1811] describes the wrongdoing and is a testimony to the rapid decline in scientific decency and the increase in censorship we have seen during COVID-19.

Also in 2024, the US Supreme Court dealt with the censorship on social media that hit honest scientists. The government had introduced harsh censorship and threatened the social media that it would have consequences if they didn't do what the government wanted. The White House used "mafiosi-style" tactics along the lines of "this is a really nice social media platform you've got there, would be a shame if something happened to it."[1812]

Martin was one of the plaintiffs. At the behest of the US government,[1813] Twitter censored his tweet - that there was no need to vaccinate children - for contravening CDC policy, and he was also censored by LinkedIn, Facebook, and YouTube. Despite being a Harvard professor, he was unable to publish his thoughts in American media, which is why he took to social media, which then blocked him.

Unfortunately, the Supreme Court decided, with a 6-3 majority, that "To establish standing, the plaintiffs must demonstrate a substantial risk that, in the near future, they will suffer an injury that is traceable to a government defendant and redressable by the injunction they

seek. Because no plaintiff has carried that burden, none has standing to seek a preliminary injunction."[1814]

This verdict is extremely worrying for the US democracy, and Harvard, once an esteemed and trustworthy source in science, has also lost its way. The firing of Martin for speaking freely during the pandemic is a disaster for Harvard's reputation. There is a petition[1815] for having Martin reinstated, but Harvard doesn't deserve to have a professor like Martin among its faculty. There is no free speech at Harvard, which in 2023 ended at the absolute bottom of student rankings of 254 US universities after a downward spiral the previous years.[1816]

## The folly of being dressed like bank robbers

During 2020, it became mandatory in most countries to wear face masks, and Cochrane played a deplorable role in this. At the start of the pandemic, Tom Jefferson and colleagues updated their 2006 Cochrane review about physical interventions to reduce the spread of respiratory viruses for the fourth time. However, Cochrane held it back for 7 months and in this period, many countries mandated the use of face masks.[1817]

This was censorship of the worst kind. The only reason to postpone publication was political expediency. The Cochrane leaders knew perfectly well how important the review was, and it became the most downloaded review in Cochrane's history.[1818] Even worse, during those 7 months, other Cochrane researchers produced unacceptable pieces of work, using substandard studies, that gave the "right answer."

Tom believes the purpose of the editorial[1819] Cochrane published to accompany his review was to undermine it. Its main message, that we cannot wait for good evidence but must act, was a complete subversion of the precautionary principle. You should do nothing unless you have reasonable evidence that the benefits outweigh the harms.

When Tom updated his review again three years later, in 2023,[1820] Cochrane committed even worse editorial misconduct. An influencer, Zeynep Tufekci, who didn't know much about masks or science,[1821] claimed in the *New York Times* that masks worked, and that Cochrane's mask review had misled the public.[1822]

Her article contained numerous errors, but Cochrane's Editor-in-Chief, Karla Soares-Weiser, apologised[1823] the same day on Cochrane's website for the wording in the review summary.[1824] She wrote that, "the results were inconclusive," and that "Many commentators have claimed that a recently-updated Cochrane Review shows that 'masks don't work,' which is an inaccurate and misleading interpretation."

It was not a misleading interpretation and there was nothing to apologise for.

Karla wrote that the review could not address the question of whether mask-wearing reduces the risk of contracting or spreading respiratory viruses, which was also wrong, as the review addressed precisely this and selected the most reliable studies, the randomised trials. So, as Tom said, Cochrane threw its own researchers under the bus again.

Karla made a colossal mistake by sending the message that Cochrane can be pressured by anyone to suicide bomb a high-quality review. Tom wondered if it was one of Cochrane's big funders that spooked her reaction.[1825]

Karla violated Cochrane's own rules and international guidelines for post-publication criticism, which should have been published alongside Tom's review, with his reply, and she didn't even inform Tom about what she would write when she short-circuited this process and rushed into action.

Three weeks earlier, Tom's review was attacked by Facebook's fact-checker *Health Feedback* with "absurd results:"[1826] *Multiple studies show that face masks reduce the spread of COVID-19; a Cochrane review doesn't demonstrate otherwise*. All eight claims the fact-checker made in her summary were void: Four were plainly false, one was logically invalid, one was misleading and two were not supported by any evidence.

*Health Feedback* also got the evidence totally wrong in relation to the Danish trial of masks for prevention of COVID-19 infection. When Carl Heneghan had written that the trial showed that face masks have no significant effect, which was true, *Health Feedback* published nonsense: *Danish face mask study did not find that masks were ineffective at reducing spread of COVID-19; study was underpowered and results were inconclusive.*[1827]

Karla's suicide bomb led to further troubles. Former CDC director Rochelle Walensky misled the US Congress by claiming the Cochrane review had been "retracted,"[1828] which was patently false. She also told Congress that the Cochrane review was suspect because it relied on randomised trials[1829] rather than the observational evidence the CDC favours. It cannot get more absurd than this.

Adding insult to injury, Cochrane's statement was interpreted widely as an apology coming from the authors, and some tweeters believed the review was retracted.

The Cochrane scandal just escalated. Karla took to communicating with Tom and his co-authors through a consulting firm, Envoy, to clean up the mess she had caused and to handle scientists' concerns about her poor leadership. Questions about how much she paid Envoy were unanswered. And Cochrane spokesperson Harry Dayantis said he didn't know anything about Envoy, which wasn't true:[1830] When Karla was forced to hire Envoy, she sent an internal email announcing this, also to Dayantis.[1831]

When Paul Thacker asked for documents that involved himself, according to Article 15 of the European Union's General Data Protection Regulation, he received redacted documents that could not elucidate how Cochrane had handled his request for comment in relation to the scandal.[1832] This, he called Cochrane's tailspin; no hope for Cochrane.

Paul also wrote that Cochrane and Envoy had ignored his questions about the contract and that Catherine Marshall, co-chair of the Cochrane Governing Board, had helped Karla draft the statement undermining the Cochrane review on masks. In her conflict of interest declaration, Marshall had failed to disclose her COVID consulting gigs with the New Zealand government, which ignored Cochrane's findings and implemented a stringent mask policy.

When Tom requested his personal data from Cochrane under Article 15, he received "nearly 300 pages of nothing" with "all the important email exchanges" fully redacted. Interestingly, the first of Cochrane's ten key principles is: "Collaboration by fostering global co-operation, teamwork, and open and transparent communication and decision-making."

Anthony Fauci said in March 2020 that masks are ineffective, and that people should not wear them.[1833] A few weeks later, he flip-flopped and recommended face masks, saying, "When the facts change, I change my mind."[1834] There were no new facts. In September 2023, Fauci said: "There's no doubt that masks work."[1835] The randomised trials had shown they didn't work, but Fauci said: "Yeah but there are other studies."

In the UK, events were similarly deplorable. In August 2023, the Royal Society published four systematic reviews about the effectiveness of non-drug interventions.[1836] All four reviews noted that the data - which were from observational studies - were biased and did not allow the readers to have any confidence in the findings. But this was ignored by the chair of the working group, Sir Mark Walport, who pronounced victory for the government's

drastic measures when there was none,[1837] As he had already been knighted, then why did he continue to please his rulers?

The media headlines were extraordinarily idiotic. *Politico*: *Top review says COVID lockdowns and masks worked, period*. *The Guardian*: *Lockdowns and face masks 'unequivocally' cut the spread of Covid, report finds*. The *I newspaper*: *Masks and social distancing did reduce Covid infections, new report shows, proving lockdown skeptics wrong*.

In February 2021, I called for a re-opening of Denmark and to make it voluntary to use face masks,[1838] but people's hearing aids were turned off. So, let's face the facts without being blinded by face masks (this cartoon was in my article):


Self-blinded researcher
Courtesy of Jyllands-Posten, cartoon by Rasmus Sand-Høyer

High-quality evidence - randomised trials - show that face masks don't work. Low-quality evidence "found strong evidence that masks work," as they said in the UK report. This is nonsense. Observational studies are biased and cannot provide strong evidence for a beneficial effect, particularly not when trials have found the opposite.

But, as Tom said, we have a very good observational study of the whole UK population. Virtually everyone has become infected with COVID-19 despite the government's mandate of using face masks and the lockdown. What does this tell us? Is anybody awake?

In June 2020, *Lancet* published a horribly poor review of observational studies.[1839] The apparent effect of face masks was likely because people who choose to wear face masks are more careful than others with hand hygiene and with keeping the distance to other people.

Two weeks later, Carl and Tom emailed the authors and *Lancet's* editors. They had found multiple data inaccuracies, and many data were implausible. When they compared the distance measures reported in a figure with the included studies, they could not replicate the results for 13 of the 15 papers. And when assumptions had been used, they could not replicate any of them. So, *Lancet* retracted the study, right? Oh no. *Lancet* did not even reply, which was editorial misconduct and arrogance in the extreme. As nothing was done, Carl and Tom published their criticism on their website.[1840] Clearly, the often-heard argument that science is self-correcting is false. It is almost a joke.

The Danish Board of Health did not believe face masks worked but they changed their opinion, referring to the hopeless *Lancet* review.[1841] They dismissed Tom's review of trials of face masks for respiratory infections with the argument that these were not corona viruses! But they have the same size as influenza viruses and spread in the same way. The Board said that there is "sufficient evidence to assume that face masks can have a supplementary preventive effect when used correctly." In science, we don't assume things, we prove or disprove them, and I have not met a single person who uses face masks correctly. People use the same mask over and over, sometimes for weeks. Face masks were a symbol of political action and of belonging to the crowd, of feeling good.

The fact that face masks don't prevent respiratory infections was unwelcome. The highly anticipated Danish results of the first randomised trial of mask wearing against COVID-19 infection was rejected by *New England Journal of Medicine*, *JAMA*, and *The Lancet* and went unpublished for five months. I criticised this delay and asked the authors to upload their trial on a preprint server,[1842] which they didn't do even though it would not have prevented their chances of publishing in a major journal.

As noted above, when the trial was published,[1843] Carl wrote that face masks do not "significantly reduce the rates of infection," which was correct. But Sonia Sodha wrote in *The Guardian* that Carl was an agent of disinformation, and "anti-science."[1844]

A large trial in Bangladesh seemed to have shown a small effect, but the 1% difference in the number of people with reported COVID-like illnesses could easily have been caused by physical distancing, which was practiced by 5% more villagers in the face mask group than in the control group.[1845] So, what did the authorities do? Referred to totally flawed observational studies.[1846]

An argument for mandating face masks is that they cannot do harm. Of course they do. Facial expressions are important for social interactions. When kids can't see each other's smiles or learn critically important social and verbal skills, this can be harmful, especially for children who are experiencing trauma. Some people are allergic to masks. The glasses can become so dewy that people cannot see, and some have fallen for this reason. You might even crash on your motorcycle. Many people, including me, hate wearing masks because they itch.

Recently, an 11-month-old baby died after being forced to wear a mask at a Taiwan daycare.[1847] The baby's mask became soaked with his tears and mucus from crying, inhibiting his ability to breathe.



On a ferry, someone greeted me, but I couldn't see it was one of my PhD students. I didn't wear a mask because my wife was bringing me coffee, but I was immediately reprimanded for this by a guy with shoulder stripes, even though she was approaching with the coffee. I drank so slowly that the coffee lasted the entire journey, a full hour, and asked my wife to take a photo of me fully masked before we disembarked. I have seen masked people on a golf course in Spain and some used masks when rowing.

My friend Kim Witczak once walked on a beath in California totally alone in the early morning when a police officer came buy and told her she must wear a face mask.

In September 2020, Canada's chief medical officer advised people to skip kissing and consider wearing a mask when having sex, adding that it was safest to masturbate: "The lowest risk sexual activity during COVID-19 involves yourself alone."[1848] As Woody Allen once said, it is so nice to have sex with one you love!

In November 2021, it was still obligatory to wear masks on the Canary Islands in restaurants. I went into one to order a table till later, without a mask. The waitress said I should put on a mask. When I replied that all the customers were sitting very close to each other without a mask, she replied that this was allowed because they would be eating soon. A German passed me on his way to the toilet, and he shouted that he was afraid of me because I was not masked. After some more discussion, I was asked to leave, with no table reservation, which I happily did. We found a restaurant where people were saner.

## The hype about the vaccines

Vaccines were developed with a stunning speed, but there were many problems with the trials, which I have detailed.[1849] All three initial trial reports are confusing to read, and essential data on harms are missing. There were only two COVID-19 deaths while there were one versus 50 severe cases of COVID-19. This was promising, but we knew nothing about long-term vaccine harms, and governments in several countries gave the manufacturers legal indemnity protecting them against being sued by patients for vaccine harms. Thus, the only ones that acquired 100% immunity were the drug companies.

In January 2021, I wrote in my book manuscript: "It seems to me that what we are confronting is like a bad influenza. Many mutations of the coronavirus have been described … This suggests that corona vaccines may be ineffective in the long run and that vaccinated people may become infected."

I was right but the hype was enormous. The American Academy of Family Physicians found it likely that the vaccine would have a stronger and more lasting immune response than natural infection, even though we know that natural infection usually provides much better immunity than vaccines.

Medical ethics went out the window. The Danish Board of Health violated its own guidelines when they wanted to vaccinate children against COVID-19, as there must be evidence that the benefits clearly outweigh the harms, which there wasn't for children.[1850]

To accelerate the development of vaccines, "human challenge trials" were carried out in the UK where volunteers were deliberately infected with SARS-CoV-2. It is not acceptable to expose volunteers to a virus that had killed millions of people. It was called "an ethical imperative,"[1851] but this is an invalid argument. We are not allowed to expose people to unacceptable risks to benefit others, which is what the Nazis did with their medical experiments in the concentration camps. A common argument was that we should vaccinate

children to protect the elderly, but this is obviously unethical. I also argued in my book that no one has the right to ask another person about vaccination status, but this ethical principle was also violated.

The prices of the vaccines were kept secret by the European Commission with the void copy and paste argument directly from the industry that it would weaken the European Union's position in future negotiations. When a Belgian minister tweeted the prices as part of a debate about government expenses, her Tweet was removed with lightning speed,[1852] but thanks to her courage, it was revealed that the price for one dose was 21 times higher for the BioNTech-Pfizer vaccine than for the Oxford-AstraZeneca vaccine.

The social media owners did their utmost to conceal the harms of the vaccines. In early 2021, someone posted a link on Facebook to EMA's database of suspected adverse drug reaction reports, adrreports.eu:


Facebook said she couldn't post this, as the "URL goes against our Community Standards on spam: adrreports.eu." So, a link to a database held by a drug regulator to suspected adverse drug reactions is spam, dangerous or "false information." The drug industry must love Facebook deeply.

In November 2021, Facebook censored a friend of mine, Juan Gérvas, for 30 days. He had argued that the COVID-19 vaccines are failed vaccines and that we must demand they be improved. I would not call them failed, but they are certainly poor vaccines. One of Gérvas' criticisms was that humanity must be revaccinated every six months, which was the advice we had in Denmark.

Facebook also blocks communication between people who are convinced they have been seriously harmed by a COVID-19 vaccine, which makes it even more difficult than it already is to find out which serious harms the vaccine cause.

A Dane who had suffered terribly after the Pfizer COVID-19 mRNA vaccine told me that people who believe they have been harmed have formed a group of almost 4,000 people in Denmark. The group does not allow anti-vaxxers in. Quite some people developed severe insomnia after the vaccination where they can only sleep for a couple of hours every night. Our top insomnia expert said he was aware of these cases.

Brianne Dressen and others who are convinced they have been seriously harmed by a COVID-19 vaccine participated in a panel discussion hosted by a US Senator in 2021.[1853] But YouTube removed the video of the 3-hour meeting deeming it "misleading" and spreading "misinformation." Today, there is a 34-minute summary.[1854]

Facebook's fact checkers removed a group to which Dressen belongs of thousands of supposedly vaccine injured people for being "false." They fought back, which involved showing medical records from 35 people, and Facebook provisionally let them back in. But for how long? Why on earth does Facebook think this is any of their business? The group was disabled because "Severe side effects of the Covid vaccine goes against our Community Standards on misinformation that could cause physical harm. We encourage free expression, but don't allow false information."

Facebook thinks it is okay to censor information about severe vaccine harms and that those who are convinced they have been harmed and try to find out what happened are denied a voice. Dressen's group was "disabled" - quite some irony considering that the members of the group *were* disabled. To such an extent that Dressen informed the panel that she knew about seven suicides and that there were likely around 15 in total.

In the article, *New England Journal of Misinformation*,[1855] David Healy described what happened when Dressen wrote to Eric J Rubin, the editor of *New England Journal of Medicine,* alerting him to fraud in an AstraZeneca COVID-19 vaccine trial the journal had published.[1856] Dressen explained that the serious harm she experienced after the first dose was not reported; that the trial smartphone app did not allow study participants to record adverse events in their own words; and that the authors stated falsely that "No new vaccine-related safety signals were identified."

Rubin, who is a doctor, ignored his ethical, academic and editorial obligations and offered a bullshit reply: "I am sorry that we will not be able to publish your recent letter to the editor. The space available for correspondence is very limited, and we must use our judgment to present a representative selection of the material received."

Next, Dressen asked if *NEJM* would issue any corrections. She noted that she was aware of another trial participant who suffered a similar reaction and was also missing from the article, and that they had reported their injuries to the NIH.

Rubin's second reply was even more arrogant and a classic Schopenhauer diversion:[1857] "We rarely publish case reports and we have no investigative powers."

Dressen replied that she had not asked for publication of a case report or called for an investigation. She had reported errors in *NEJM* that required correction.

Rubin replied that, "The best we could do is forward your letter to the manufacturer. Only they are in a position to see the primary data. But you can do that yourself and I would encourage you to do so. Only you can provide the information that they can use to investigate."

Brilliant! When presented with evidence of fraud in their journal, *NEJM* asks people to contact the fraudster. What a society we would have if this was how the police reacted when you reported serious crimes to them.

Dressen pointed out that Rubin's reassurance that the manufacturer had the data was wrong, as AstraZeneca stopped recording data on her at day 60.

I have supporting evidence that AstraZeneca committed fraud in its COVID-19 vaccine trials. When my wife got the vaccine, she became terribly ill. She had not been so sick in her entire life, apart from a single experience of influenza. She could not sleep, her temperature was 38.7°C; she had nausea, dizziness, no appetite, felt miserable, had severe headache and muscle aches that lasted for several days, and needed to stay home from work for four days. On day three, she was slow-cerebrated in a way our family had never experienced before.

It was unlikely that she had incidentally acquired a nasty virus infection at the same time as the vaccination. The first 13 colleagues at her hospital department also became so sick from the vaccine that they needed a sick leave even though they all liked their job.

By definition, when you can't work, it is a severe adverse effect of a drug or vaccine in clinical trials. So, 100% in her department had a severe adverse effect. But in AstraZeneca's trial report in *Lancet*, only 1% had a severe adverse reaction.[1858] I had never seen such a large discrepancy before between what a company publishes and what people experience. By far most of the subsequently vaccinated 35 people at her department also became so sick that they needed a sick leave. Denmark stopped using the AstraZeneca vaccine.

Maryanne Demasi has faced lots of trouble from Facebook. A reader had his Facebook account restricted when he shared an article where she discussed if it is a good idea to vaccinate small kids.[1859]

Maryanne's webpage has been "shadow banned." This is not a covert CIA operation but a block that prevents users from knowing about the ban. Facebook works in the shadows like criminals do. The hope is that the user will become frustrated and leave the site.

Big Brother does not even tell you that he has blocked your messages. It was impossible for others to access Maryanne's article even when she used another access route. There is nothing in her articles about COVID-19 that justifies any form of censorship. She is very careful with getting the science right and don't draw unwarranted conclusions. She makes people think, which Facebook's ridiculous "community standards" do not allow.

Even articles praising vaccines can be subjected to censorship. A doctor wrote about the dangers of vaccine hesitancy and praised the near-miraculous developments of the COVID-19 vaccines.[1860] He said that "scientists don't know what to do to stop the viral spread of hateful disinformation, coronavirus's most loyal ally." Facebook inserted a meaningless sentence: "COVID-19 vaccines go through many tests for safety and effectiveness before they're approved. Source: World Health Organization."

This misinformation should have been labelled "false" by Facebook! Due to the emergency, the vaccines *were not* tested adequately but were rushed through. It was only *after* they came into general use that we discovered that they could cause lethal blood clots and myocarditis (inflammation in the heart). Facebook echoed the drug companies that always refer to the many tests for safety and effectiveness when corpses land on their table.

I have described in detail a Facebook fact checker's unwillingness to admit his wrongdoing in a case of falsification of data in Pfizer's COVID-19 vaccine trial.[1861] The whistleblower, Brook Jackson, was fired by Pfizer's research contract organisation as she was deemed "not a good fit."

When Paul Thacker had written about the affair in *BMJ*,[1862] readers reported they were unable to share it. Facebook called it false information and directed readers to a fact check[1863] performed by a Facebook contractor named Lead Stories, which the *BMJ* editors found to be inaccurate, incompetent, and irresponsible.[1864]

Lead Stories refused to change anything, and Facebook refused to remove the "fact checking" label and links to the Lead Stories article and to allow the readers to freely share the article on the platform.

*BMJ* then wrote an open letter to Mark Zuckerberg, co-founder and CEO of Facebook, raising serious concerns about the fact checking. They noted that Thacker's article was published following legal review, external peer review and was subject to *BMJ's* usual editorial oversight and asked Zuckerberg to act swiftly. Zuckerberg did not reply and *BMJ's* many appeals, including to Meta's Oversight Board, led nowhere.

I tweeted about the calamity. Lead Stories saw my tweet and retweeted: "You should read this first if you believe any 'censoring' went on. Our reply to *BMJ's* open letter."[1865]

I responded in a new tweet: "Lead Stories' reply is pathetic, which you can see if comparing it with the *BMJ* letter to Zuckerberg," and published my observations in *BMJ*.[1866]

In all his self-righteous, irrelevant empty rhetoric, and unwillingness to admit his failures, the reply from Lead Stories' Dean Miller to *BMJ* is scary. He is not a young, inexperienced late comer who might be excused; he is Managing Editor of Lead Stories with a long editing experience but propagates plain, unadulterated nonsense. Miller deceives his readers

deliberately, lies about the facts, attempts character assassination, violates basic rules of logic, and uses the guilt by association trick.

This story is much bigger than Miller and Lead Stories. There are numerous other stories about busybody fact checkers, which raise a pertinent question. Social media get a large part of their income from advertisements. Could this be the reason why Lead Stories was completely unreasonable in relation to one of the richest drug companies in the world?

We don't know how best to fight the social media monsters. Their blockage of democracy, open societies, and scientific debate makes me think of the religious police in Iran, the Taliban, Russia, the Chinese Communist Party, Orwell's *1984*, and Trump in 2025.

Lead Stories work with the CoronaVirusFacts/ DatosCoronaVirus Alliance, a coalition of more than 100 fact checkers who are fighting misinformation related to the pandemic. The website for the Alliance constantly blocked my computer when I tried to navigate on it. Its opening page states that "When the new coronavirus pandemic started, many hoaxes were about the origin of the virus."

As I was convinced, they also got the origin of the virus wrong, I tried to find out what the earliest fact checks said about it, but this was also difficult. I searched on origin, but even though I sorted the posts with the oldest ones first, the dates were not in any order. I therefore had to go through them manually.

There was a fact check by FactCheck.org, which said: FALSE: **The origin of the novel coronavirus was "manipulated"** … Explanation: Experts have refuted the claim that the virus is "not naturally occurring."

This is utterly false. Experts have never refuted this claim. The fact is that it is highly likely that SARS-CoV-2, the virus that caused the COVID-19 pandemic, escaped from a laboratory in Wuhan, and that it was manufactured there.

I read the full article, which addressed a documentary called *Plandemic* that went viral on social media.[1867] I looked up other information sources, which confirmed most of the statements about *Plandemic*. It weaves a grand conspiracy theory by using a host of false and misleading claims about the pandemic and much else.

The video is largely an interview with Judy Mikovits, a discredited American researcher whose many outrageous claims include: "They will kill millions as they already have with their vaccines;" "If you've ever had a flu vaccine, you were injected with coronaviruses;" and "Ebola couldn't infect human cells until we took it in the laboratories and taught them." She also claimed that hydroxychloroquine is effective against COVID-19 and that using masks could lead to people infecting themselves with their own breath!

Mikovits published a book, *Plague of corruption: restoring faith in the promise of science*. The irony couldn't be bigger. It has a foreword by Robert F Kennedy Jr., and on Amazon, we are told that:

"Dr. Judy Mikovits is a modern-day Rosalind Franklin, a brilliant researcher shaking up the old boys' club of science with her groundbreaking discoveries ... From her doctoral thesis, which changed the treatment of HIV-AIDS, saving the lives of millions, including basketball great Magic Johnson, to her spectacular discovery of a new family of human retroviruses, and her latest research which points to a new golden age of health, Dr. Mikovits has always been on the leading edge of science."

This colossal praise is false. Rosalind Franklin was an X-ray crystallographer who played a pivotal role for the discovery of the molecular structure of the DNA, the double helix.

I investigated the claims by searching on PubMed, with *Mikovits J* in the author field and *retrovirus* in the title field. There were only four results. The first had nothing to do with the

discovery of a retrovirus. The next, from 2009, in *Science*, was retracted in 2011. The third was a similar publication in *Virulence*. The fourth was a short notice in *science* stating that Mikovits et al. retracted two figures and a table.

In July 2011, *Science* published an expression of concern.[1868] They noted that Mikovits et al. had reported that a retrovirus called XMRV was present in 67% of patients with chronic fatigue syndrome (CFS) compared with 3.7% of healthy controls, but that, since then, at least 10 studies conducted by other investigators had failed to detect XMRV in CFS patients.

In December 2011, *Science* retracted the article explaining that multiple laboratories, including those of the original authors, had failed to detect the virus and that the authors had omitted important information.[1869] Mikovits didn't discover anything and might have committed fraud.

Simon & Schusters' homepage tells us that Mikovits' book is "#1 on Amazon Charts, New York Times Bestseller, USA Today Bestseller - Over 100,000 Copies in Print!" It is a colossal tragedy for public health that the worst books about vaccines sell the most.

Coming back to FactCheck, they wrote that the genetic features of SARS-CoV-2 indicated it was neither created in a lab nor manipulated, and they quoted the infamous article by Kristian G Andersen and colleagues that didn't show anything at all (see page 428). As the fact check was updated in June 2021, it is inexcusable that it accepted this information, which others had deemed false numerous times.

The fact check said that the NIH grant to Wuhan was used to "conduct genetic analyses of the viruses ... aimed to analyze the risk of coronavirus emergence and help in designing vaccines and drugs to protect us from COVID-19 and other coronavirus threats." This was fraudulent. It was not a passive study of genetics - the genomes provided by nature - it was about fabricating entirely new, deadly viruses!

Other fact checkers were equally hopeless. When a colleague posted a message on Facebook about one of the best articles ever written about the origin of the pandemic,[1870] his post was removed. The justification was a 4,184-word fact check by *Health Feedback*, with 16 references.[1871] Yet again, the fact checkers claimed that Andersen had established that SARS-CoV-2 is of natural origin, and they used superlatives to further their case, e.g. the 27 people that signed the misleading *Lancet* letter (see page 427) were called eminent scientists, which is persuasion by referring to authority.

Maryanne Demasi and I did a systematic review of the serious harms of the COVID-19 vaccines, which we published on my website, as medical journals rejected it.[1872] The adenovirus vector vaccines increased the risk of venous thrombosis and thrombocytopenia, and the mRNA-based vaccines increased the risk of myocarditis, with a mortality of about 1-2 per 200 cases. We also found evidence of serious neurological harms, including Bell's palsy, Guillain-Barré syndrome, myasthenic disorder and stroke, likely due to an autoimmune reaction. Severe harms, i.e. those that prevent daily activities, were underreported in the trials but were very common in studies of booster doses after a full vaccination and in a study of vaccination of previously infected people. We concluded that the balance between benefits and harms becomes negative in low-risk groups such as children and people who have already recovered from COVID-19 infection.

Even our foot-dragging authorities acknowledged that some people are killed by the vaccines, and in May 2024, the AstraZeneca vaccine was withdrawn worldwide. Officially for commercial reasons, but the company admitted that the vaccine may cause thrombosis, which was linked to at least 81 deaths in the UK.[1873] Most appallingly, the UK drug regulator

refused to make public data on the relationship between deaths and vaccine doses for "commercial confidentiality reasons."

Where was Cochrane in all of this?[1874] When Cochrane published a review of the vaccines, the authors used industry jargon in the title, *Efficacy and safety of COVID-19 vaccines*,[1875] even though I convinced Cochrane 20 years ago that we should talk about benefits and harms, in agreement with the CONSORT guidelines for good reporting of harms in trials, which I coauthored in 2004[1876] and in its 2023 update.[1877]

Yet again, Cochrane also failed in relation to harms. The authors said there was little or no difference in serious adverse events compared to placebo, but when Peter Doshi and colleagues used regulatory data to reanalyse the pivotal mRNA trials, they found that one serious adverse event occurred for every 800 vaccinated people.[1878] They also found that the harm was considerably larger than the benefit - avoiding hospitalisation Their article was published four months before the Cochrane review came out, but was not cited.

Doshi et al.'s criticism of the Cochrane review is published within the review. It is so substantial that we should call the Cochrane review a politically expedient garbage in, garbage out exercise, rather than "trusted evidence," which is Cochrane's motto.

The COVID-19 vaccines are much overused and partly to the wrong people. Now that most of us have been infected, recommending booster after booster is a particularly bad idea. EMA first suggested to give boosters every three months,[1879] even though we don't know what this will lead to, but in an extraordinary back-flip just one month later, it warned against repeated boosters because it might overload people's immune systems.[1880]

YouTube would not have allowed Maryanne, me and Doshi to propagate our findings. They trust the authorities, which poses a "serious risk of egregious harm," which YouTube say they try to avoid.

Absurdly, YouTube's Vaccine Misinformation Policy stated that we are only allowed to post material about harms of vaccines that have been recognised by health authorities. However, countless times, the authorities' reassurance that a drug is safe and effective was proved wrong after it had killed many people.[1881]

YouTube did not allow content saying that vaccines do not reduce transmission or contraction of disease even though this is an essential problem with some vaccines. It is also forbidden to say that influenza vaccines can cause permanent harm; that vaccines can kill people; and that the HPV vaccines can cause "chronic side effects," even though all these statements are absolutely correct.

According to YouTube's extremely detailed COVID-19 Medical Misinformation Policy, content contradicting local health authorities' information was not allowed, but authorities disagree wildly, even within the same country, e.g. in the USA. YouTube also banned people from saying face masks don't work or that they may cause harm even though both statements are correct (see page 440).

It was even forbidden to say that that there is a guaranteed prevention method for COVID-19. But I know one: Stay at home, alone, receive no visitors, get your food delivered outside your front door, and open the boxes with gloves on. Then you won't get COVID-19.

It is forbidden to say "that any medication or vaccination is a guaranteed prevention method for COVID-19." This should have made YouTube's and other social media's fact checkers very busy. Among those that have claimed 100% efficacy of the vaccines are the FDA,[1882] Anthony Fauci,[1883]the Australian government,[1884] *Science Magazine*,[1885] *Reuters*,[1886]

*CNN*,[1887] *US National Public Radio*,[1888] *The Hill*,[1889] *Sky News*,[1890] Pfizer,[1891] Moderna,[1892] AstraZeneca,[1893] and Johnson & Johnson.[1894]

Fauci and President Joe Biden declared in interviews that people cannot get infected if they have been vaccinated. A health magazine even claimed that this false information had been fact checked:[1895]


health

✓ Fact-Checked

The Johnson & Johnson Vaccine Is 100 Percent Effective at This One Thing

THIS IS WHY DR. FAUCI SAYS THE NEW VACCINE HAS SHOWN "SPECTACULAR RESULTS."

So, what was the basis for the false claim? *Reuters* noted that, "Two weeks after the second dose, researchers found no cases of COVID-19 in the vaccine group compared to 4 cases in the placebo group, resulting in a vaccine efficacy of 100%."

As there were 2489 versus 1243 patients in the two groups, this means that 2489 patients (100%) in the vaccine group were not infected, compared to 1239 patients (99.7%) in the control group. This is a totally different message than claiming 100% efficacy. Furthermore, the effect is highly uncertain as it is based on only four patients.

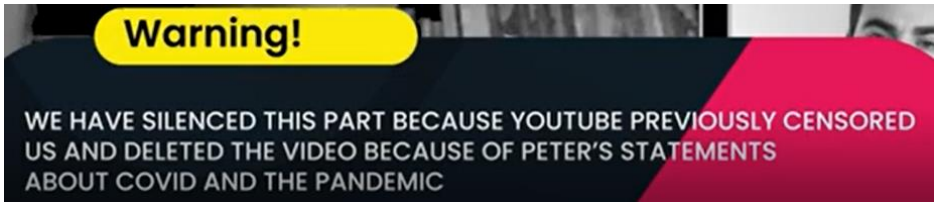
Six months later, the study was published,[1896] and the miraculous effect was gone. The article reported vaccine efficacies of 93%, 70%, 56%, 60%, and 39%. Pick one but remember that the effect of the COVID-19 vaccines is much closer to 50% than 100%. Many of us, including my wife and me, have had COVID despite being fully vaccinated.

The poor effect of the vaccines was not the main reason why some of us protested[1897] when the UK government in December 2021 wanted to introduce mandatory vaccination of healthcare staff like they had just done in the USA,[1898] with the support of the American Medical Association.[1899] It is a gross violation of informed consent to ask people to run a personal risk hoping to benefit others, and vaccination does not protect against COVID-19 or prevent transmission of the virus to other people.[1900]

Already a month later, the decision about obligatory vaccination was abandoned, with peculiar arguments.[1901] The omicron variant was less severe than the delta variant, and there were acute workforce shortages and record waiting lists in the NHS.

In 2022, I was interviewed by *enGrama* in Spain about organised crime. YouTube instantly eliminated the interview.[1902] The interviewers had recorded the interview directly on YouTube and they asked YouTube to allow them to download their video, but to no avail.

A month later, they had solved the problem, but it had required quite some work to resuscitate their video. They deleted the five minutes where I talked about COVID-19 and the vaccines and uploaded the video again with this warning:




What I said was that I was convinced it was a lab leak and that the virus was manufactured in China. I also said that Canadian researchers had shown that the more times you get vac-

cinated against influenza, the greater the risk of infection with another virus strain,[1903] and I noted that the European Medicines Agency had cautioned against repeated boosters with the COVID-19 vaccines because they could weaken the immune response.

I noted that in Germany, people could be arrested if they said something that disagreed with official policy, and that the authorities often disagreed with themselves.

I also mentioned our review of the serious harms of the COVID-19 vaccines,[1904] and that people could die, e.g. because of myocarditis, which is one reason why I was against mandatory vaccination with a COVID-19 vaccine.

## Quackery, fraud, corruption, and abuse of power

Anti-vaxxers touted useless treatments such as ivermectin and hydroxychloroquine. The studies that looked best for ivermectin came from regions with high rates of infection with threadworm (*Strongyloides*).[1905] As the drug is used to treat worms, this is likely the reason it performed better in worm-infested areas.

A researcher in Sweden received multiple death threats after he made comments about French microbiologist Didier Raoult who falsely claimed that hydroxychloroquine was effective, based on a small, fatally flawed study with no control group,[1906] which was later retracted.[1907] As of 2024, 28 of his research publications have been retracted, and at least another 218 papers have received an expression of concern from the publishers.[1908]

Hydroxychloroquine was touted by President Trump and his lawyer, Rudolph Giuliani, who claimed 100% efficacy.[1909] Trump announced he would send 2 million doses to Brazil,[1910] and the FDA buckled under to the political pressure and issued an emergency authorisation, which was later rescinded.

The large WHO Solidarity trial[1911] found that hydroxychloroquine increased mortality and increased the use of ventilation and hospital stay. The results were uploaded on a website already in October 2020, but even in 2022, all sorts of conspiracy theories flourished that involved the WHO, Bill Gates and Big Pharma and the evil in withholding a miraculous and cheap drug that could save many lives.

In China, President Xi Jinping promoted quackery. He stated that "Traditional medicine is a treasure of Chinese civilisation embodying the wisdom of the nation and its people" and praised it for its "unique" contribution to fighting the coronavirus.[1912] Over 90% of patients with COVID-19 received traditional remedies.[1913]

Another quack is Dolores Cahill from Ireland. A patient I had inspired to withdraw her psychiatric drugs wrote to me that I should attend a World Freedom Alliance meeting in Copenhagen. I looked it up, but curiously, the announcement for the meeting didn't say what it was about, but I recognised the name of one of the speakers, Dolores Cahill. She has a doctorate degree in immunology, but "her crusade of misinformation raises the question of how far academic freedom goes."[1914]

Cahill claimed that COVID-19 is a hoax if you are under 65 and have no underlying conditions; that the COVID-19 vaccines would kill many of the elderly; that COVID-19 can be prevented by vitamin C, vitamin D and zinc; that the most efficient treatment is hydroxychloroquine; that children wearing a mask would be starved of oxygen and see their IQ lowered; and that the RNA-based vaccines do more harm than good.

All of this is false. Unbelievably, this woman has also been active in the field of scientific integrity. Arguing against physical distancing, Cahill claimed that only three organisms are

transmitted via the air, tuberculosis, smallpox, and Ebola. She apparently never heard about measles, influenza, and the common cold.

Students at her university wrote a 33-page scientific rebuttal of her claims, signed by 133 people, and sent it to the administrators. The university sheepishly referred to their guidelines on academic freedom as a reason for their inaction.

Cahill is the president of the World Freedom Alliance, which has a youth wing embracing the notion of "natural law," by which institutions and their laws are not recognised, only "the Creator's laws."

Cahill is an example that some well-educated people are predisposed to finding attention, money, and a large following of idiots by becoming a religious leader or a contrarian guru, especially in the middle of a public health crisis, which saw the rise of many such fools.

In November 2020, *BMJ's* editor wrote a scathing editorial explaining how COVID-19 had unleashed state corruption on a grand scale where science was being suppressed by politicians for political and financial gain, and where industry, scientists, and health experts contributed to the opportunistic embezzlement.[1915] He noted that politicisation of science, which was enthusiastically deployed by some of history's worst dictators, is now commonplace in democracies.

The prime minister introduced mass screening based on a poor antibody test. When researchers pushed to publish their study findings on the poor performance before the government committed to buying a million of the tests, they were blocked by the health department and the prime minister's office. Subsequently, Public Health England unsuccessfully attempted to block *BMJ's* press release about the paper. And the government didn't care the slightest bit that many of its experts had numerous financial conflicts of interest and could favour their own products and those of friends and associates.

The UK government's chief scientific adviser was Sir Patrick Vallance who was president of Research and Development at GlaxoSmithKline from 2012 to 2018 and owned shares in the company worth £600,000. Astonishingly, when confronted with this, the minister of health, Matt Hancock, denied that there was a conflict of interest.[1916]

There was a huge scandal related to the antiviral, remdesivir (Veklury). The investigators changed the primary outcome - deaths - shortly before their trial was published in May 2020 and replaced it with the time it took patients to recover.[1917] This was fraud. The preliminary results were published in the *New England Journal of Medicine*, but apparently disappeared, as I have only been able to find the final report, published six months later.[1918]

I explained that we did not know what the true value of the drug is.[1919] Two of the trial authors, Danish professors Jens Lundgren and Thomas Benfield, touted remdesivir as a miracle drug, and even though it had no significant effect on mortality, Lundgren said that if the drug was given at the right time, it could reduce mortality by about 80%. Benfield called the results "totally unbelievable," which indeed they were, but not in the sense he imagined.

When Benfield was interviewed about the trial in our medical journal, he declared as a conflict of interest that he was an investigator in the trial. However, on the homepage of *New England Journal of Medicine*, he had listed grants and personal fees from Gilead (the manufacturer of remdesivir); "unrestricted grants" (a euphemism for corruption) from Pfizer, the Novo Nordisk Foundation, Simonsen Foundation, and GSK; personal fees from GSK, Pfizer, Boehringer Ingelheim, and MSD; and grants from the Lundbeck Foundation. A bit more than just being an investigator.

When the results from the much bigger WHO Solidarity trial were published, it became clear that remdesivir does not reduce mortality,[1920] and it was puzzling that a Chinese remdesivir trial had not found any reduction in viral load,[1921] without which it is difficult to imagine that the drug could work.

Gilead entered an agreement to supply the European Union with remdesivir for $1.2 billion.[1922] They received the WHO data two weeks earlier but did not reveal them to the European Commission, which only learned they had been fooled the day after they had signed the agreement with Gilead.

There was corruption everywhere. In its review that granted remdesivir approval, the FDA ignored the WHO trial and the placebo-controlled trial in China. In the USA, Gilead sold $873 million of its ineffective drug in just three months, as the Trump administration had secured almost all of Gilead's supply during that quarter.[1923] And even though the WHO recommended against using remdesivir, EMA approved it.

In 2024, Denmark decided to destroy its reserves of two other antivirals, Lagevrio og Paxlovid, worth 400 million crowns.[1924] Only one-tenth of the purchase had been used during the pandemic, partly because people didn't believe the drugs were effective.

Denmark also had a mink scandal. After a mutation was found in the virus in mink, with decreased susceptibility to antibodies from previously infected people, assumed to render a vaccine less effective, Prime Minister Mette Frederiksen ordered all 17 million Danish mink exterminated immediately.[1925]

The order was illegal, and one of the mass graves was also illegal, as it was much too close to a lake. Other mass graves posed a pollution risk to the drinking water supply. The decomposing bodies of the mink soon resurfaced as what the media dubbed "zombie mink," and the mink were therefore exhumed and burnt.

Denmark was the largest producer of pelts in the world, and we had three times as many mink as people. Kåre Mølbak from the State Serum Institute warned the government that the mink farms could become a new Wuhan, but when journalists later found this out and asked for a comment, he refused. I argued that public servants who work for taxpayers' money have an obligation to respond when journalists ask questions in the common interest.[1926] It should be punishable by law when such people or politicians decline to comment to protect themselves.

Mølbak retired surprisingly early. The mutant had likely died out two months before the mass killing was ordered, and many experts, including from the WHO, expressed scepticism over Danish government claims that the mutation could seriously undermine vaccine efforts. Only a week after Frederiksen had declared that all mink should be killed, Danish experts concluded that there was no reason to be worried about the mutation.[1927] I am against breeding wild animals in tiny cages but that's another matter.

Frederiksen was Prime Minister for a minority government but had acted dictatorially without involving the Parliament, which was another huge mistake and unlike the consensus-seeking approach that dominates Danish politics.

During the scandal, I was interviewed in the TV news, and I asked what we should do if we encountered a pandemic of swine flu, and a mutation arose in Danish pigs. Should we then also kill our 25 million pigs? I doubted that would happen.

The compensation to the mink farmers cost about 4 billion Euros, but Frederiksen was not held accountable for her harmful actions. Our government sent both the police and

military to North Jutland to scare the lives out of the farmers, even though the extermination order was illegal.

For the most of 2020, every time I turned on the news, it was corona, corona, corona. There was nonstop media coverage with every talking head, opinion columnist, or self-appointed amateur expert weighing in on how it was going. Our lives were pestered by counts of new cases, admissions, and deaths, as well as endless press conferences with the prime minister, the minister of health, and the heads of the Board of Health, the Serum Institute, and the police, who were all constantly worried and asked for further sacrifices.

It was like a new worldwide religion, something that was supposed to unite us, as if eternal life lay ahead if we did not die from COVID-19. We must never forget how awful all this was.

"Test, test, test," said WHO Director-General, Tedros Adhanom Ghebreyesus on TV. Testing is essential for contact tracing, but testing most of the population repeatedly is irrational. The Danish government announced in December 2020 that they had made it possible to test over 200,000 Danes per day! This meant that the whole population could be tested every month, at a price of 1.4 billion Euros a year, or far more if people went to private test centres.

It was totally crazy. As there was no discussion in the media about how reliable the tests were, I worked it out. The PCR test is highly accurate if used when infection is suspected, but it performs poorly when used as a screening test. With a disease prevalence of 0.5%, which was the case at the time, 81% of those who test positive are false positives, i.e. they do not have COVID-19.[1928] Why did people not point out in the public debate that when so many people are tested, by far most of them will be false positives?

The mass testing led to huge human suffering.[1929] Many people tested positive long after any possible infection, flip-flopped between positive and negative tests, could not visit their loved ones, or lost their holiday or money for no good reason because several countries required a negative test taken within the last three days before leaving the airport.

Maryanne Demasi and I described this mega-silliness in *BMJ* in April 2021.[1930] In the UK, everyone should be tested twice a week, which also applied to Danish school children. In Denmark, in the last week of March 2021, 1.1 million PCR tests were carried out in a population of only 5.8 million. An enormous number of healthy people were declared ill and were isolated, and many contacts were asked to be tested, too. It was total chaos. Countries called for introducing vaccine passports even though the WHO was against it. Furthermore, it was plausible that vaccinated people could transmit the virus anyway because the antibodies were in the blood, not in the nasal mucosa.

It went from bad to worse when highly unreliable quick tests were introduced, which experts called "beyond reckless." Even flu vaccination became a condition of employment, although the flu vaccines are poor.

**WHO's farcical tour to Wuhan**

A WHO expert team went to China in January 2021 to investigate the origins of COVID-19. WHO's negotiations with China began when the pandemic started and took almost a year, but shortly before departure, the team was denied entry to China.[1931] Tedros Adhanom Ghebreyesus, WHO's Director-General, was very disappointed about this, and two members had already begun their journeys.

The team, which included Peter Daszak, kept asserting before, during and after their visit that a lab escape was extremely unlikely even though the Chinese had no evidence to offer the commission in support of the natural emergence hypothesis.[1932] This contrasted with the outbreaks caused by the SARS and MERS viruses, which had left copious traces in the environment, and where intermediary host species were quickly identified.

When the WHO team finally arrived, the inspection was a farce. The team members could not get access to important data, which were heavily controlled by the Chinese authorities, and only 4 of the 313 pages of the report and its annexes addressed the possibility of a laboratory accident, which Ghebreyesus found insufficient.

A sound principle, particularly in research, is that if you have nothing to hide, then hide nothing.[1933] Open your lab books. It can only be beneficial, as it will increase your trustworthiness. But the Chinese had a lot to hide. Shi made untruthful statements, became foul early on, asking critics to "shut their stinking mouths," and continued to cover up the facts.

Unfortunately, brainwashing is very effective. When I said a lab leak was by far most likely, e.g. to my tennis partners, they said "Can you prove this?"

The massive propaganda by Beijing and its useful idiots has been so effective that people believe in something that is extremely unlikely, with no evidence whatsoever in its support, whereas if we tell people what is extremely likely, we are asked to prove it!

The Chinese cover up
Courtesy of Jyllands-Posten, cartoon by Rasmus Sand-Høyer

Of all places, a coronavirus outbreak erupts on the doorstep of a national institute that has one of the world's largest collections of such viruses and where they experiment on them to make them more infectious and more deadly. Yet, the Chinese want us to believe that COVID-19 came from bats living in caves 1500 km away and that it is not possible that the extensive collection of faeces and other material from these bats could have anything to do with the outbreak in Wuhan. In their desperation, the Chinese have also tried to put the blame on a military base in the USA, on mink in Europe, on Italy and India, and on imported frozen food.[1934]

China is responsible for many millions of deaths and the USA is complicit. Whatever one thinks of the origin of SARS-CoV-2, it is obvious that if the Wuhan Institute of Virology had not conducted gain-of-function research, and therefore had not collected more than a thousand samples of coronaviruses from bat caves far away and experimented on them, there would not have been a pandemic.

Gain-of-function is a euphemism for gain-of-lethality research. A witty guy suggested that the smart virologists should perform lack-of-function experiments instead.

Six months after WHO's inspection in Wuhan, Danish TV2 broadcast a brilliant documentary, *The virus mystery - a Dane hunts for truth in China*, featuring WHO's head of the mission, Peter Ben Embarek from Denmark. He was unusually outspoken for a long-time WHO employee. As the documentary is essential for understanding the scale and nature of the Chinese cover up of the origin of SARS-CoV-19, I have published a comprehensive summary.[1935]

The only thing I missed in the documentary was that it does not discuss the genome of SARS-CoV-19, which is a smoking gun, as it contains genes that do not occur naturally in these viruses.

The documentary punctures totally the Chinese plead for innocence and explains in detail how far the Chinese went to conceal the origin of the pandemic. Chinese researchers were forbidden to continue their research collaboration with overseas researchers, and this was controlled by President Xi Jinping. The WHO team collaborated with 17 Chinese researchers, and all would need to agree with everything in the report. It was very difficult for Embarek to convince the Chinese that something needed to be said about a possible lab leak. Forty-eight hours before the end of the mission, when there was still no agreement that this would be mentioned, Embarek threatened his Chinese counterpart that without such mention, there would be no report. This was accepted on the condition that there would be no recommendations about any specific studies to be carried out.

The TV2 journalist failed miserably when saying that a lab leak was "a more controversial theory." What was controversial was the natural origin and the cover up. Wuhan's blood bank had 200,000 samples from 2019 but the WHO was not allowed to analyse them even though they could have led to identification of the first patient.

While saying they always acted openly and transparently, China denied everyone access to the bat cave where the virus samples came from and the virus databases in Wuhan disappeared. The WHO did not see any documentation about how the Wuhan Institute of Virology had actually worked with gain-of-function and the different coronaviruses.

When Embarek said at the press conference that a lab leak was extremely unlikely, the interviewer asked: "Was it a requirement from the Chinese side that it must be called extremely unlikely in order to get it into the report at all?"

Embarek: "This was the category that we chose at the end, yes. What it says is that it is not impossible, but it is not particularly likely. This is how it should be read."

Interviewer: "But had it been included if it had not been called extremely unlikely?"

Embarek: "Uhm, this would probably have required a, a ... perhaps even more (laughs) discussion and argument for and against, and I did not think it was worth it."

Text on the TV screen: In May 2021, USA's President Joe Biden gives his intelligence service 90 days to come closer to a conclusion about the origin of the pandemic. The report is expected to appear by the end of August. China immediately hit back and called the suggestion a "conspiracy."[1936]

And it gets worse. Text on the TV screen: On 16 July 2021, the WHO comes up with a plan for further studies in China. Among other things, they suggest audits – which are in-depth investigations of relevant laboratories in Wuhan.

Ghebreyesus: "We are asking actually China to be transparent, open and cooperate."

Zeng Yixin, vice minister in the National Health Commission, China: “I feel that the plan ignores common sense. It defies science.”

Text on the TV screen: China rejects WHO’s plan about further studies in China.

The Danish TV programme was picked up by international media, e.g. *BMJ* in the article, *COVID-19: China pressured WHO team to dismiss lab leak theory, claims chief investigator*.[1937] A Swiss epidemiologist named Wilson Edwards claimed the exact opposite, that the USA had pressured the WHO into falsely blaming China for the pandemic. The claims were picked up by *China Daily*, *CGTN*, *Global Times*, and *People’s Daily*, with the headline, *US attempts to overturn report, leveraging WHO into political tool*. Edwards was likely a fake, invented by China. He had no scientific publications, and after investigations, the Swiss government branded the Chinese reports “fake news” and asked for their removal.

On 23 July 2021, the *Washington Post* published a most damning editorial exposing the extent to which China lied about the facts and the White House condemned China's opposition to probe into COVID-19 origins, which was called dangerous and irresponsible.[1938]

A week earlier, Ghebreyesus had called on China to cooperate and be transparent, and he said that both major hypotheses for how the pandemic began should be investigated. But “China slammed the door in his face.”[1939] The rejection of WHO’s plan by Zeng Yixin, vice minister of the National Health Commission, and Yuan Zhiming, director of the biosafety lab at the Wuhan Institute of Virology, was so absolute as to beggar belief. China’s propaganda mouthpiece, *Global Times*, quoted Zeng as saying that the Wuhan Institute had never conducted gain-of-function research that would examine whether viruses could be modified to improve their ability to infect.

Yuan said that the institute “did not contact, preserve or study the novel corona-virus, and it never designed, made or leaked the virus.” No employees or students were infected, and no pathogen leakage or human infection had occurred in Wuhan’s high-level biosecurity lab since it was put into operation in 2018.

This says it all. China’s “bat lady” Shi Zhengli had published an article in *Nature Medicine* about a gain-of-function experiment,[1940] but even this was denied by China.

Does this surreal country exist at all, or is it just a bad dream? I wish it were. Maybe we shall see more hugely deadly virus pandemics “Made in China.”

# 17 Three whistleblowers

A whistleblower is someone who, in the public interest, reports an activity that is illegal or immoral, e.g. fraud, abuse, corruption, or a danger to public health. People say it takes great courage to become a whistleblower, but does it? The many whistleblowers I have met all did it because they felt it was the right thing to do, without speculating about the consequences for themselves or feeling courageous.

It's not wise to tell a gangster you have observed his crimes. It's also a bad idea to tell a drug company you work for about its crimes, which were highly likely planned at the top. According to Peter Rost, a global vice president of marketing for Pfizer turned whistleblower, Pfizer's lawyer thought that anyone who tried to resolve criminal acts within the company and keep his job was a mental case.[1941]

Rost noted what happened for 233 whistleblowers in cases of fraud: 90% were fired or demoted, 27% faced lawsuits, 26% needed psychiatric or physical care, 25% suffered alcohol abuse, 17% lost their homes, 15% got divorced, 10% attempted suicide and 8% went bankrupt. Despite all this, only 16% said they wouldn't blow the whistle again.

Richard Smith, previous *BMJ* editor, said that when potential whistleblowers called him, he told them they had a duty to act but would likely to be badly damaged as a result, likely affecting their whole life.[1942] One of them said that "Every whistleblower is an amateur playing against professionals." Richard also noted that "Most of us don't blow the whistle because we recognise where the power lies. The state, the university, our employer, or the professor will crush us."

Whistleblowers usually act for deeply held moral reasons. They are very rare, but some of the most wonderful people you can meet. I have also met many great pioneers, e.g. in Canada, the US, Brazil, Argentina, the UK, Denmark, Norway, Holland, Germany, France, Italy, Spain, and Australia, who have done a lot to make the world a better place, often at great personal risk. And I have seen many fantastic initiatives being destroyed because they are always powerful interests in keeping the *status quo*. Whether their activities saved billions of any currency for their country didn't matter. In fact, it only increased their risk of getting eliminated because many people in high positions benefit from the widespread corruption. If you demonstrate that a colleague is corrupt or has committed fraud, your reward could very well be that you lose your job.

Lawsuits have shown how drug companies systematically persecute critical doctors. Merck had a spreadsheet with named doctors and the staff responsible for haunting them, and an email said: "We may need to seek them out and destroy them where they live,"[1943] as if Merck had started a rat extermination campaign. There were details about each doctor's influence; of Merck's plans; and the outcomes, e.g. "NEUTRALIZED" and "DISCREDIT."

The threats can be particularly malicious - even death threats[1944] - when scientists have found lethal harms of drugs the companies have concealed. In 2008, one of my colleagues, Jens Lundgren, received a death threat at the international AIDS congress in Mexico City in an SMS sent a few hours before he presented data showing that GlaxoSmithKline's £600 million drug, abacavir, doubles the risk of heart attacks.[1945] The organisers also received threats, and when Lundgren had finished his talk, he was escorted to the airport with eight bodyguards.

The biggest differences to gang crime is that the gorillas in healthcare are usually not hitmen but lawyers, and that doctors do not get murdered.

A lawyer phoned a Danish journalist who had written critically about the drug industry based on my research and said he called on behalf of a friend. He asked how she got access to documents, the company considered strictly confidential. He wouldn't reveal who his client was. He called again and said that journalists who are critical towards the drug industry may lose everything, their family, friends and job. The journalist got very scared and didn't sleep much that night. I know her but she prefers to be anonymous.

I have often wondered why I have been exposed to so many evil attacks and monstrous lies during my entire career whenever I showed that something people believed in wasn't true. But then I came to think of the greatest people I have known and worked with, those at the absolute top, morally and intellectually. Then, I got it. Like them, if I had been a professor and head of a hospital department, I would have welcomed any new research that told me that we could help our patients better if we changed our routines. The whole idea with being a doctor is to help patients as much as we can. So, my conclusion is that many doctors don't have sufficient humility, integrity, ethics, and intelligence to behave properly when solid research demonstrates that their beliefs or own research are wrong.

I shall now tell the story of three remarkable whistleblowers.


Maryanne Demasi


Peter Wilmshurst


Charles L Bennett

**Maryanne Demasi**

Australian journalist and PhD Maryanne Demasi is a very close friend and collaborator. I first met her when I lectured in Sydney in 2015 on my Australian lecture tour (see page 150).

Maryanne worked for the Australian Broadcasting Corporation (ABC) for 11 years where her role was to investigate science issues and, if warranted, challenge orthodoxies.[1946] In 2013, she produced a two-part series, *Heart of the Matter*, which cited evidence challenging the role of cholesterol in heart disease and the overprescription of statins.

The series aired with huge praise from the public and topped the ratings. Maryanne and her team were applauded by all levels of ABC management for "superbly presented, provocative and intelligent programs," for achieving a "timeslot crushing rating performance" and receiving "a public vote of confidence in great journalism."

But the praise didn't last long. The drug manufacturers and others with vested interests rallied their forces and went to war. They screamed blue murder, ramping up attacks in the media. "People will die" and "ABC has blood on its hands," they cried.

The media response was swift and disproportionate. Experts did not challenge the scientific merits of the programmes; instead, they chose to shoot the messengers.

The ABC launched an internal investigation. After six months, the panel concluded that both programmes were factually accurate but that one section "unduly favoured one side" of the debate, the side that cautioned against mass prescription of statins.

The conclusion was that the two programmes should remain available to the public, but ABC didn't care.[1947] It made a review that came to another conclusion about impartiality, and, without warning or compunction, the ABC banned the programmes from the website. A fully referenced webpage dedicated to extended interviews, scientific papers, and all the evidence to back up the thesis had been censored and replaced with an apology.

There had been strong reactions in parts of the medical profession.[1948] So-called experts attacked the programme even before it aired, using the familiar "you are killing my patients" and *ad hominem* arguments. Professor Emily Banks, Chair of the Advisory Committee on the Safety of Medicines in the Australian drug agency, wrote to ABC that the programme was a series of anecdotes from "fringe-dwelling scientists or people who weren't actually scientists." This wasn't true. Those interviewed were among the best researchers in the world in this area.

Maryanne and her team were gagged from making any public comment and threatened with expulsion if they disobeyed ABC's order. Secret documents revealed that the food industry giants attacked Maryanne for challenging their marketing messages; there were attacks in social media and industry-sponsored propaganda by so-called experts paid to undermine her credibility; critics called for her sacking; and there were vexatious complaints about her scientific integrity. Ultimately, the whole team was axed.

News of the ABC's capitulation attracted international criticism. Doctors were outraged by the injustice, calling for the programmes to be reinstated. Several books were published, referencing the controversy.

The documentaries are available on the Internet,[1949] and I saw them shortly after they aired. They are of superb quality, not partial at all, and provide very important information to the public.

As noted in a book, the way in which this was handled did no service to the credibility and integrity of Australian experts and bureaucrats, who performed the disappearing act with all the grace of a rutting bull elephant seal.[1950] The presenter of ABC's radio's *Health Report*, Dr Norman Swan, said the programme made him "really angry" and he warned that "people will die" as a result of the TV programme's messages. However, ABC's internal report didn't support his claims of causing any harm to the public.

To add insult to injury, Mark Scott, Managing Director of ABC, in his proforma letter of response to public complaints, ignored this fact and suggested that the programmes were removed due to the potentially serious health implications.

The ABC interviewed the National Heart Foundation, a charity heavily funded by statin manufacturers that wrote the statin guidelines, and they and Norman Swan claimed that thousands would die because they dumped their statins, based on a study funded by Merck (a statin manufacturer), but an analysis showed that statin prescriptions dropped by only 2.6% in the months after the programme was aired.[1951] Moreover, one of the central issues in the programme was that statins are much overprescribed for primary prevention, i.e. to healthy people who have never had any cardiovascular issues, which is still true to this day.

Programme producers are rarely able to distinguish between real experts and powerful people, the eminences, many of whom are financially conflicted in relation to the drugs under scrutiny. This is why the public is often exposed to flawed programmes that don't make them any wiser. *Heart of the matter* was a rare exception. The ABC and Norman Swan

should have apologised to the Australian public for acting in a patronising and paternalistic fashion, which implied that Australians are too dumb to figure out fact from fiction and need to be protected from the facts, which they are supposed to be unable to handle.

The ABC was easily influenced by the eminences and failed miserably in its mission to present controversial subjects to the public in a courageous manner that challenges the prevailing belief systems.

I noted in the *BMJ* that the Cochrane review of statins for primary prevention reported that 3% more patients developed muscle pain on drug than on placebo, but also that industry-funded randomised trials are notoriously unreliable in relation to the harms of drugs.[1952] A publicly-funded randomised trial from 2012 that studied the impact of statins on energy and exertional fatigue suggested that 20% of the men and 40% of the women experience a worsening in either energy or exertional fatigue.

I therefore wondered why Sir Rory Collins had pressured *BMJ* in a most unacademic fashion to retract a paper that reported a similar high incidence of harms based on a cohort study. Collins and his colleagues publish meta-analyses on statins and other drugs based on company data to which no one else has access because of confidentiality clauses. When only those who have conflicts of interest are allowed to see the data, it is not science.

Maryanne is one of the best documentarists in the world and she is a superb writer, too, but she became the victim of brutal character assassination. Every newspaper ran with the same narrative and would not allow anyone to publish a defence of the programme in their editorial sections. They published only negative reviews that sought to discredit the programme. Part of this was the jealousy of other journalists who enjoyed watching the demise of one of their colleagues who was a competitor in the small pool of Australian journalists. And part of it was extremely lazy journalism. It was easier to jump on the hate bandwagon than spend time to find out what the truth was.

A particularly evil person was Australian professor David Vaux. He joined the lynch mob and accused Maryanne of scientific misconduct for work she had carried out almost 20 years prior. Because of the allegations, Maryanne's PhD thesis underwent intense scrutiny. The University of Adelaide found “no motivation, rationale, intent or any actual wrongdoing of any kind.” Investigators from Monash University, Macquarie University and the University of New South Wales, as well as a former Supreme Court Justice who served as Chair, agreed with Maryanne’s legal team.

Maryanne and her PhD supervisors said that she was within her right to duplicate specific data in some images, because it was a universally accepted practice at the time to reuse baseline or control values when they did not represent different experimental conditions.

Maryanne was fully exonerated on all allegations made against her by Vaux. The investigation panel noted that the allegations were made by a “professional complainant and activist” who had also submitted a complaint against the University itself, accusing it of a cover-up despite carrying out a lengthy and expensive two-year investigation.

That didn’t stop Vaux, however. He succeeded to convince a medical journal that had published Maryanne's images that it should retract her paper from 2003 despite her being cleared of wrongdoing. The journal insisted on obtaining the original images, but the University discarded most of the records after 14 years in storage. The rule for retaining original records was 7 years but this didn’t matter to the journal; they were making up their own rules.

It was an unfair storm in a teacup. One cannot judge something that took place 20 years ago with today’s standards or laws, but this was what happened.

Maryanne and her co-authors asked if the journal would allow them, in an addendum to the article, to explain to the readers their reason for duplicating baseline values, but the journal didn't allow this, which was appallingly poor judgment.

Journalist Ivan Oransky wrote a defamatory article about Maryanne in *Retraction Watch* and made sure no one would miss the point by labelling her "controversial" in his title.[1953] This was also pure evil. Maryanne was not controversial. She was honest, which went against powerful interests.

Notably, Vaux refused to appear as the complainant in Maryanne's tribunal hearing to present evidence under oath because he didn't want to be cross-examined on his evidence by her legal team. The legal advisors said this was a breach of procedural fairness rules and insisted that Vaux be cross-examined. But he decided to not show up at all and also lied about the events. He told Oransky at *Retraction Watch* that he wasn't allowed to appear at the tribunal hearing. Oransky published the falsehood in his article and refused to correct it, most likely because Vaux was on the Board of Directors of *Retraction Watch* and Oransky was afraid of upsetting him.

Vaux praised the journal for retracting the paper and opined that "Their standard of research integrity stands in stark contrast to those of the authors, inquiry panel members and University of Adelaide."

This baloney is quite telling for Vaux's character. He sees himself as being above everyone else, even investigators from three universities and the lawyers that represented his side, but he resides at the bottom where kangaroo courts operate. Such courts ignore recognised standards of law or justice, carry little or no official standing; may ignore due process; and come to a predetermined conclusion.

Maryanne was victimised to such a degree that she could not find work in the Australian mainstream media where she could use her qualifications. This is a huge loss for Australian journalism and the rest of the world.

I was proud when Maryanne accepted to become my deputy director at the Institute for Scientific Freedom. She lectured about the ABC scandal at the opening of my institute in 2019[1954] and also at CrossFit headquarters where we both lectured.

Our institute is not funded, and I very much hope the public will support her ongoing research and investigative projects, which can be done via her website[1955] where she publishes about 50 interesting articles every year, which are all listed on the institute's homepage.[1956]

**Peter Wilmshurst**

UK cardiologist Peter Wilmshurst also lectured at the opening of my institute.[1957] He has described fraudulent science many times and he once came close to bankruptcy and losing his home.[1958]

Peter was one of two principal investigators in a clinical trial whose purpose was to find out if closing a hole in the heart, the *foramen ovale*, would improve migraine. The trial was sponsored by a US company, NMT Medical, the maker of the STARFlex implant.

During a US cardiology conference in October 2007, Peter expressed concerns that the trial data were not being reported accurately, and he was interviewed by a journalist who published an article on a cardiology website. This caused NMT to start legal proceedings against Peter for libel and slander in the English High Court. NMT behaved as gangsters and subjected him to immense stress. He received the legal papers on Friday, 21 December 2007

at 5.09 p.m., 9 minutes after most solicitors had closed for Christmas, and it was not until the next year that Peter was able to get legal advice.[1959]

NMT sued him twice more. Once, after he gave an interview about being sued for libel on the *BBC Radio 4 Today programme* even though their lawyers had said that this would not result in a further claim. *BBC* was not sued, and NMT made no attempt to have the episode removed. It was all about harassment. The bullying worked, as other doctors were reluctant to speak out about the harms caused by NMT's devices.

When the trial report had been accepted for publication in *Circulation*,[1960] Peter and another member of the trial steering committee refused to be authors and sign a false declaration that they had seen the trial data and took responsibility for their integrity.[1961] They had contributed more than 30% of the patients, but Peter's name didn't appear anywhere, not even in the acknowledgements, although his work had inspired the study; he had been a principal investigator; had taken a major role in designing the trial; had contributed substantially to the paper; and had been a member of the steering committee.

In contrast, a prominent cardiologist, who died before the trial began, appeared as author, also in a letter in *Circulation* five years after his death in reply to criticism of the trial, even though Peter had told the editors that he was dead.

The investigators had been informed at the outset that they could see the raw data, but NMT refused to let the authors see them. Peter documented to the editors that the paper was fraudulent, and 18 months later, a correction of 700 words, a four-page data supplement, and a new version of the paper were published. This was also false.[1962]

NMT lied maliciously about Peter. They alleged in the original online article that he had been thrown out of the trial for committing protocol violations and that he had lied when he said he was a principal investigator even though NMT's own press releases had named him this way.

Peter's lawyers advised him against countersuing NMT although he would win. As he would not be able to enforce an English court's judgment in USA, neither his costs nor damages would be recovered. He needed to get advice about defending the case in each US State because the laws differed. NMT could say whatever they wanted about him with impunity and the English defamation laws allowed them to sue him for telling the truth.

The implant didn't work. The migraine stopped in 3 of 74 patients with a STARFlex implant and in 3 of 73 in the sham procedure group.

Peter and another cardiologist showed that there were significant residual shunts in the heart in 33 and 27 patients, respectively. But NMT decided that only the assessment by the implanting cardiologists would be published. When they assessed their own performance, there were only 4 leaks.

The trial report did not mention that the implanted device fell out in some patients, a potentially lethal complication. Moreover, NMT had tortured their data. They redefined the secondary outcomes and removed some patients from the analyses, which led to monstrously erroneous claims, e.g. a 50% reduction in headache in 42% of the patients, which remained on NMT's website over two years after a reanalysis had shown it to be false.

NMT published the photographs, names, and testimonials of the three patients who had become migraine-free after a STARFlex implant on a rotating banner on their website and in their annual report. Similarly rosy comments appeared on the website of the Royal Brompton Hospital, which was one of the large centres for the trial. They removed them when Ben Goldacre informed the hospital that he intended to discuss the misinformation in his Bad Science column in *The Guardian*.

None of the libel cases against Peter came to a full hearing. They lasted nearly four years and collapsed in April 2011 when NMT went bankrupt.

Peter's legal costs were about £320,000. At the end of 2010, he made the Courts order NMT to pay £210,000 into an account controlled by the Court when it appeared the company was in financial trouble. As Peter only got two-thirds of his costs back, most of his lawyers said they would only charge two-thirds of their fees. Peter was therefore left with costs of about £25,000. He cannot recover the enormous amount of time he spent dealing with the legal documents, which took virtually every evening and weekend and all his annual leave for three years. Neither was his family compensated for the stress resulting from fear of being made bankrupt and the possible loss of their home.

The other principal investigator, Andrew Dowson, was the first author on the fraudulent paper. He was found guilty of multiple counts of misconduct in the trial and was suspended from the Medical Register by the General Medical Council. He appealed to the High Court, but the judge rejected his appeal. Dowson owned shares in NMT but had assured the ethics committee in writing that he didn't own shares, and he also gave his affiliation as a well-known hospital although he had treated his patients in private practice.

Peter is still trying to get *Circulation*, owned by the American Heart Association, to retract the fraudulent paper from 2008, with no success.[1963] He did all the right things but was severely punished for it.

**Charles L Bennett**

Charlie Bennett sends very short emails. The first contact I had with him was in March 2022: "Peter I follow your work a. Bunch. I support you. As well. Charlie. Bennett."

My reply was even shorter: "Which country?"

Later that year, Charlie submitted an abstract to our meeting about the lack of scientific freedom where he spoke via a video link from a cruise ship about 26 clinicians and scientists who were intimidated and threatened by academia and pharma after communicating findings contrary to corporate interests, which he published an article about.[1964]

In 2023, I noted on an email list that I worked with two filmmakers on a documentary film about fraud and crime in the drug industry and was looking for a whistleblower. This project stalled because we couldn't finance it, even though we had interviewed and filmed highly interesting people. But Charlie volunteered and alerted me to an interesting book a lawyer and his wife had written about him.[1965]

When I told Charlie about the USA filming tour I had planned with Janus, from Chicago and westward, he offered to come from South Carolina to Chicago for an interview, which we arranged.

Charlie suffered from great injustice when he reported the results of a meta-analysis in *JAMA* that showed that erythropoietin (EPO) products, which were widely used in cancer patients with anaemia, increased mortality by about 10%. He was Professor at Northwestern University in Chicago, and the university immediately went into action. Not to support him, but to discredit him and get him fired. It turned out that several of the Northwestern board of directors profited from the largesse of Big Pharma.

The university was clever. They hired a person to investigate 20 years of Charlie's grant funding from the National Cancer Institute. This person reported to the Department of Justice that the University, the cancer centre director, and Charlie had committed grant

administration fraud. This can be discussed. There was no finding of guilt on anyone's part and settlements with the Department of Justice were negotiated.

An FBI investigation showed that the cancer centre and the university had been deceived by Charlie's administrative assistant Feyi who had embezzled $86,000 of National Cancer Institute funds from Charlie's grant which she used for her wedding and subsequent honeymoon. She had accomplished this by creating a fictional company.

The day before Charlie presented his meta-analysis findings at the largest international cancer conference in the world, he met with Amgen's then vice president, Roy Baynes, in the lounge of the hotel. Charlie had sent Amgen a draft of his findings prior to reporting them at the conference, and Baynes insisted that the paper was unworthy of publication. He ended his criticism with an ominous threat: "If you publish this, I will destroy you."

An assistant US attorney from Washington state who was spearheading a separate case against Amgen because the company had misled consumers and distorted scientific papers about its products, sent Charlie a large box of relevant material that the court had required Amgen to turn over for the lawsuit. In Amgen's internal communications, several people had stated that something needed to be done to limit Charlie's influence.

Charlie's meta-analysis was used as evidence by the FDA to restrict the use of EPO in cancer patients. Amgen was forced to fire 1,500 employees, its market capitalisation decreased by $22 billion, EPO's annual sales decreased by 95%, and the take-home personal revenue of the average oncologist (all of whom were heavy prescribers of EPO before Charlie's work was published), decreased by $150,000 annually. An estimated 100,000 cancer patients' lives had been saved by not using EPO.

There was no due process by the Department of Justice or Northwestern. Northwestern lied brutally to the Department of Justice about Charlie. The University knew very well that his assistant had deceived him and that he was innocent but issued an official statement that was false. Even today, eleven years later, there is a prominent posting in a Google search that includes the purposely mistaken opinions by the President, Provost, and Dean about Charlie. The clear import is that Charlie administered federal funds in a manner "at odds with university policy and its culture of compliance." Curiously missing is that allegations are relevant only if they are proven. The letter implies that Charlie himself was guilty of major misappropriation of grant funds, which cost millions of dollars along with heartache to the blameless leaders of Northwestern.

The joint statement of the President, Provost, and Dean does not mention that neither the Department of Health and Human Services nor the Department of Justice found any evidence that Charlie had used grant funds for personal or nonscientific reasons.

As Charlie's case demonstrates, it is possible to put together a legally elegant complaint with no proof of wrongdoing - based on *possible* violation of government rules and failure to follow accounting standards with respect to expenditures. This is similar to what Cochrane did to me.

The witch-hunt was astounding. Charlie even received notice that his medical license would be revoked, but after personally paying $30,000 in cash to the head of the medical licensing board, this decision was downgraded to a "reprimand" that allowed Charlie to continue his medical care of prostate cancer patients. He has little doubt that the government's relentless focus on him via the Department of Justice was based on pressure initiated by Amgen. You might have guessed by now that Amgen is an American company.

Even though Charlie did nothing wrong, the affair cost him over one million dollars in legal fees and a settlement with the Department of Justice, an 80% decrease in his annual

salary, and a relocation to a pharmacy school. He was required to pay a $475,00 settlement and was told that if he didn't have the money, they would be happy to accept his retirement accounts or his house to complete the payment! Charlie gave the Department of Justice his house. The money was due in one day or a 17% monthly interest on the money would be incurred. I thought only the mob took such interest rates.

Periods of depression were inevitable, and Charlie's wife Amy said that "it's a miracle that he's made it through all of this - he's threatened suicide … And he's been tossed off all of the scientific and corporate boards he was on. He was sought after, on all these committees." She remains furious that his career has almost been destroyed.

Charlie has identified and reported serious and previously unreported adverse reactions for 74 drugs and devices. He showed that fluoroquinolones, such as levofloxacin and ciprofloxacin, used against infections, can cause serious neurologic and psychiatric harms. His team identified 122 patients who had committed suicide following initiation of one such drug, and 45% of them died within two weeks of starting the drug.

Since the FDA, as always, didn't react, he filed "citizen petitions" with the FDA requesting that the fluoroquinolone labels be corrected and include information on suicide and possible permanent neurologic and psychiatric toxicities. He and a person who was ten years into this severe fluoroquinolone toxicity developed a nationwide campaign to encourage quicker and more decisive FDA action, which centered on local television news interviews in 51 different US cities with Charlie, plus local people who had been seriously injured by one of the drugs.

When the Foot Dragging Agency, after four years, finally reacted, they watered the warnings down. They didn't put cardiac or neuropsychiatric issues in the black-box warning, and they didn't use the word "disability." Essentially, the changes were meaningless.

Charlie is now a whistleblower in a case in the federal appeals court in New Jersey against Johnson and Johnson, the original manufacturer of levofloxacin. He alleges they defrauded the FDA for 35 years by not reporting details of the neuropsychiatric toxicity even though thousands of persons are likely to have suffered permanently from this. If the lawsuit prevails, the US government will receive 2 billion dollars, and Charlie 600 million dollars to share with his lawyers. There could also be further investigations allowing Charlie to look for a smoking gun in corporate emails. If Charlie's lawyers do not win this appeal, then there is a good chance that the United States Supreme Court will revisit the theory of "fraud on the FDA." This lawsuit is viewed by some as one of the most important cases involving the pharmaceutical industry ever. Attorneys in the Attorney's General office in Washington DC have filed a "friend of the court" memo supporting Charlie's lawyer's claim that the manufacturers have committed fraud on the FDA. This is an almost unheard-of helping hand from the Department of Justice and should have a positive influence of the Appellate Court's decision which is expected to come soon.

There could also potentially be a movie about the whole thing. Al Ruddy, co-producer of *The Godfather*, supported the book about Charlie, as did also co-producer Grey Fredrickson.

Charlie could not find work anywhere, as he was blacklisted after he left Northwestern. Luckily, he succeeded in getting an endowed chair at the Pharmacy School at the University of South Carolina, where he leads a centre that evaluates drug harms. As reported on the cover of the book about Charlie, he might have saved more lives than anyone else in American medicine.

# 18 My experiences with professional incompetence as a patient

Even if you are a doctor, or on your way to become one, you may be exposed to colleagues that are so incompetent that they endanger your life unnecessarily.

This happened when I, in all likelihood, had malaria, and when I diagnosed myself with ileus, which the hospital on two occasions denied in the most absurd and uncaring fashion. I was also close to having stents inserted in my coronary arteries, which would have been medical malpractice, and which I only avoided by pure luck. I have had many odd experiences as a patient and shall describe some of them.

## Malaria

The lethal variant of malaria, falciparum malaria, takes many lives. Travelers returning from risk areas should therefore have a blood sample examined for parasites if they get a fever or other symptoms compatible with malaria in the twelve months following their return.

This is well-known but was ignored in my case. In 1980, about a month after my return from Kenya (see page 43), I developed symptoms that were highly suggestive of falciparum malaria. At the time, we used chloroquine for malaria prophylaxis even though the parasites were often resistant to the drug.

My symptoms worsened, with alternating periods of shivering and sweating every third day, which is typical of falciparum malaria. I was in a terribly bad condition, with muscle pains and diarrhoea, and when I went to the toilet, I experienced excruciating pain when my feet touched the floor. It was as if someone stabbed me in the brain for every footstep.

I lived alone. I called for two different doctors who came to see me. They didn't find it necessary to have my blood examined for malaria, even though I asked to be admitted to hospital to have it done. They knew I had just come home from Kenya after a journey under primitive conditions and that I studied medicine and was very scared that I might have falciparum malaria. That didn't impress them at all.

One of the doctors, Henrik Langseth, a general practitioner, was disdainful. He said I had a virus infection and shouldn't be worried. When I asked for a blood test, he replied that those who called themselves specialists in tropical medicine knew no more about it than other doctors; they had just attended a course in London where they peered into a microscope for a couple of weeks.

So, just by looking at me, the wise guy could tell I didn't have malaria! This is where my story becomes interesting for others. What exactly should we do in such situations?

I have been anti-authoritarian all my life and have always questioned the "know-it-all" types. I knew that my blood must be examined. Yet this doctor's self-confidence paralysed me. I didn't want to bother other people unnecessarily, and it didn't occur to me to take a taxi and go to an emergency ward. The thought of calling an ambulance was even more remote.

Today, I fail to understand how I, of all people, could be so gullible. The rational part of me was screaming that my doctor was wrong.

I cannot say this strongly enough: If you feel uncomfortable about your doctor's advice, don't accept it. It might kill you (see also page 78, about meningitis).

Somehow, I got through my ordeal alone. I recovered, and when I visited my usual doctor and was at long last sent to a specialist in tropical diseases, it was too late to find any malaria parasites. I underwent a lot of tests, but nothing was found.

Two months after my recovery, I experienced the same symptoms again, with 3-day fluctuations in body temperature, but much milder. Since I knew a lot about malaria, I didn't worry about this. Falciparum malaria can come back within a year in a milder form, and after that, you are cured - in contrast to the benign forms of malaria where the parasites can remain dormant in the liver for many years and then suddenly cause a new attack. But I regret I did not have a blood sample examined during the second attack.

When I told my story to colleagues, they often said that people don't survive falciparum malaria and that I must have had another disease. This is not correct. Most children in Africa survive, and most European explorers, missionaries and scientists recovered when there were no effective drugs.

Seven years later, I worked at the Department of Infectious Diseases at Rigshospitalet and told my story to one of the chief physicians, Ove Jessen. He found it very likely that I had survived untreated falciparum malaria, as no other disease could explain my symptoms.

I once flew out of Heathrow to India with Air India and was highly surprised to see a steward spraying something foul-smelling. There was no declaration of the ingredients on the canister. I asked him why he sprayed in the entire cabin. Well, this was to prevent insects from being brought to India. I laughed and told him that, yes, there had been a few cases of malaria near Heathrow.

There were other amusing surprises. A Sikh steward asked me if I was non-vegetarian. I responded that I was not a "non-thing;" I ate most things, and I was not a non-female or a non-homosexual, either. He didn't appreciate my humour but an Indian sitting next to me did. He explained that many Indians, Hindus for instance, only ate meat once a week or not at all, and that the steward's question was therefore reasonable.

Some doctors, me included, don't take malaria prophylaxis because we know that our blood must be examined if we get ill and that there are effective drugs. It is also an issue that prophylaxis can be harmful.

We published a paper about neuropsychiatric harms caused by mefloquine, a drug that was commonly used for prophylaxis.[1966] I also co-authored a randomised trial of prophylaxis that included 767 Scandinavian travellers to Kenya and Tanzania.[1967] Seven people (1%) developed falciparum malaria, even though most of them spent less than four weeks in East Africa.

## Nursery plague and other infections

Infections are common when there is overcrowding and poor hygiene, e.g. in nurseries and kindergartens. Many kids and their parents suffer immensely from virus infections, which we call nursery plague. I was particularly hard hit and often coughed for months and slept badly, too. I also developed secondary bacterial pneumonias in need of antibiotics.

I often wondered whether creating all this misery for so many people is really the best way to arrange childcare. We escaped for a while by arranging daycare in our home, with another family's child, but when this could no longer continue, our illnesses returned. As we couldn't take any more of this, we talked to the head of the nursery about it, in the most diplomatic way we could, emphasising the importance of hygiene for limiting the spread of

infections. We got nowhere. The nursery head was highly defensive and totally resistant to our arguments.

However, years later, disinfectant alcohol dispensers had been installed in the institution which the staff used. Still, there had been many odd discussions about whether people might become allergic to the disinfectant or if the children might be harmed by it.

Hygiene is the best public health remedy we have. But being low-tech, it is difficult to convince even health professionals, particularly males, of its importance. At an international surgery congress, 20% of the males did not wash their hands after visits to toilets.[1968]

When I have a cold, I tell people why I avoid shaking hands. Washing hands before eating is also a good idea. You might have picked up infectious particles, and viruses can survive for weeks and spread from solid objects you have touched.

I 1999, I came close to dying during a holiday in Canada with my wife and youngest daughter. When visiting Algonquin Provincial Park, we went to an island in a lake by boat and could not come back before the next morning. I became ill during the afternoon, and it got considerably worse during the night. The next morning, I was in a very bad shape and couldn't drive the car. Helle drove us to the nearest town where I got penicillin and recovered very quickly. I had sepsis, likely with streptococci.

## Sleep apnoea

One of my funniest experiences stems from my irresistible urge to fall asleep in the most precarious situations. I suffer from sleep apnoea, and my sudden bouts of loud snoring after not having breathed for a whole minute sound like the roar of a ferocious animal which wakes up both Helle and myself.

I was sometimes exhausted and sweaty during the day and wanted to sleep at the most inconvenient times, e.g. when driving a car or at dinner parties. The urge to sleep could be so intense and painful that I had to leave the party to take a nap, excusing myself with not feeling well, which was true and did not make my companions think I found them boring.

In 2009, I gave in and visited an ear, nose, and throat specialist who handed out some equipment to monitor my sleeping pattern. When he saw the recordings, he suggested removing the uvula and possibly other tissues, which I refused. I told him there were no data from randomised trials showing that such surgery worked; moreover, it could be harmful. He then suggested continuous positive airway pressure (CPAP), which I accepted not knowing that its benefits were doubtful.[1969]

He referred me to a sleep centre, and I asked him to forward the sleep recordings. When the sleep specialist wanted to make recordings, I told him it was unnecessary, as the diagnosis was indisputable and recordings had already been made.

The specialist unpacked a CPAP set and explained how to use it. He mentioned I could get a special permit to carry the apparatus as hand luggage when I was flying. I replied that I did not want look like a desperately ill patient and did not want the pity of onlookers.

He explained that, after being turned on, it took 20 minutes for the apparatus to start working, allowing people to fall asleep. He also said that if the inhalation pressure was too high, I could adjust it, but he did not tell me how.

Back home, I unpacked the CPAP apparatus, feeling badly about my new role as an intensive care patient. I usually fall asleep immediately but, lying there with a face mask, I just waited until the apparatus started working. It inflated me like a balloon. It was very unpleasant, and my throat dried out. I consulted the instruction manual, which was about a hundred

pages long, but couldn't find any advice about reducing the pressure. I gave up, dismantled the machine, and fell asleep.

Helle convinced me to give it another try, but the same sequence of events unfolded.

On the third day, I read the manual more carefully and found a page which, curiously, considering its dire text, wasn't located at the beginning of the manual. Under no circumstances should anyone use the apparatus without reading that page, it said! Well, very clever to hide it then. I found out that if the apparatus malfunctioned, I might rebreathe the air and die peacefully without triggering any alarms, and without any intensive care nurse rushing to my rescue. Startled by this, I searched PubMed and the Internet but found nothing about the risk of this lethal complication.

My condition did not justify any risk of dying from the treatment. I looked up the science and found some observational studies suggesting that sleep apnoea increases the risk of cardiac disease. But so many things in life increase this risk, and observational studies are often misleading.

During my next visit to the sleep centre, the specialist asked how it went. I told him and returned the equipment. Referring to the recordings, which he had now received from the surgeon, he said that my sleep apnoea was mild, and he would not have recommended the apparatus in the first place. He based his judgment on the recordings rather than on my symptoms, which were pronounced. He also said that CPAP was only considered to work at certain ages and was not recommended after age 70. Approaching 60, I replied that I saw no reason to use his terrible apparatus which might even kill me.

I told my story to Steven Woloshin from Dartmouth, New Hampshire, who remarked that most patients cannot tolerate using CPAP. In one study, only 2 of 35 patients used CPAP for seven hours for at least 70% of the nights.[1970] That would have been nice to know.

My short guest visit as a patient was "interesting," as the Brits say when it is worse than that. I lost my autonomy to the doctors who told me what to do. I was happy to drop the patient role, and my symptoms gradually lessened.

I published the story in the *BMJ* that requested I included the sleep specialist as co-author.[1971] He wrote that obstructive sleep apnoea occurs in up to 24% of men and 9% of women. Of course. Everything becomes common when specialists decide how common it is. He also wrote that surgery could be used in some cases, even thought there was no evidence in support of this.

He noted that my dramatic symptoms contrasted with the objective recordings and that this was not unusual. Then, why on earth was he so interested in the recordings and based his judgment on them? Where can I find doctors' sense of logic? Just a little, please.

Discrepancies are common in healthcare, which is why the patients' experiences are usually far more important than what doctors' can measure with their instruments.

## Angina

My short career as a heart patient is also interesting. In 2010, aged 60, I ran fast for my age in a 4 x 5 km relay. After 4 km, I got a strange feeling in my chest that prevented me from running. Since I had never had any heart problems and didn't have any risk factors, I was surprised this happened to me. After a short break, I resumed running but was forced to stop again because of cardiac arrhythmias and the same oppressive feeling.

Some days later, I ran again, and the symptoms returned, with a pulse that was way too fast, at 200, or irregular. I lowered the pace and finished the run without problems.

Some months later, it became so bad that I needed to walk home because the arrhythmias came back every time I started running, even at low speed.

I got a heart monitor from the hospital, and the recordings showed occasional sinus tachycardia, probably atrial fibrillation and runs of four ventricular tachycardias during my sleep, which worried me. I was subjected to a stress test, which was clearly positive even when I ran at a slow pace with no symptoms. I didn't know how unreliable stress tests are, and my doctors and I had no doubt that I had coronary heart disease.

It took me some time to get used to my new patient role. I found out by how many times my death risk had suddenly increased and felt I had stepped out of my usual, "Don't worry be happy" attitude to life and had arrived in the antechamber of death.

I was put in a hospital bed next to a young man with blocked coronaries due to a hereditary condition. His father died very young. I felt very sorry for him and even for myself. So, these people are my new companions, right? No longer fellow sportsmen but people predestined to die much too early. One of the bad things about being in hospital is that you are in company with very sick people. This doesn't bolster your self-confidence.

The next day I was supposed to have one or more stents inserted into my arteriosclerotic arteries. I am still surprised I accepted this. But it happened so quickly that I had too little time to think and investigate. I knew - contrary to what people think – that coronary bypass operations do not prolong life; they only have a symptomatic effect. I supposed the same was true for stents and I didn't like the idea of having tubes in my coronaries. Furthermore, my ailments were minor. I had no problem playing tennis. I could give up running and use my racing bike more instead.

There I was, lying on the table with a catheter in my groin artery, which was a painful procedure, awaiting the inevitable. I would leave my wonderful world of freedom and enter the land of sickness, dependency, despair, and death. Life would never be the same.

Then the cardiologist said, "Turn the screen so that Peter can see his arteries." I was stunned. My coronaries were as smooth as in a newborn. What on earth was this? My cardiologist said I was a false positive and recommended that I continued running as much as my symptoms allowed. I agreed, but I was not a false positive, my troubles were real. I asked the doctor who had subjected me to the stress test to explain it. He couldn't. We all knew that, very rarely, people could have spasms in their arteries. I assumed this was the case.

I kept running, sometimes 8 km every day together with Helle. When we ran too fast and I got uncomfortable arrhythmias, I paused for a few seconds. My symptoms went away, in just 1-2 years. And no one knows what it was. But life doesn't always go downhill.

I wondered why the cardiologists wanted to insert stents in me when my problem was so banal and easy to live with. I had stable angina, and if I had done my homework, I would have refused being stented, no matter what my coronaries might have looked like.

The science shows that the harms of stents include death, perforation of the artery, stent thrombosis, emboli, heart attack, bleeding or infection of the access site, bleeding in the abdomen, stroke, and acute kidney failure. Holy smoke! I had exposed myself to all those risks for no good reason. And do stents improve survival in those who need them? No. Outside of an emergency, they are not known to be lifesaving or to prevent heart attacks.

On my way to a meeting in the Ministry of Health, the guard at the entrance pointed to the elevator, but I asked: "Isn't this the Ministry of Health?" I told him that elevators are only for handicapped people and deliveries. I always use the stairs, two steps at a time, and will consider myself very old when I cannot do this any longer.

I tried to make the hospital and the health authorities aware of the malpractice I had been exposed to, as I wanted to protect other patients. I came nowhere, which frustrated me so much that I wrote about it in a newspaper 13 years after I had experienced it.[1972]

I first informed Centre Director at Rigshospitalet, Rasmus Møgelvang, about the incident, no to avail. I asked to see their guidelines for insertion of stents, but did not receive anything meaningful. Møgelvang had discussed my query with the chief physician, Professor Thomas Engstrøm, who replied that the patient is always guided in the choice of treatment, including that medication can be tried first. In doing so, the department passed a judgment on itself. Medicine is not optional, it must *always* be tried first according to the international guidelines, which my colleague, cardiologist Harlan Krumholz from Yale, confirmed.

I then wrote to the Board of Patient Safety that it is a serious medical error to insert a stent without trying medication first, and that stents increase the risk of sudden death and other serious complications. I asked the Board to ensure that this cannot occur at Rigshospitalet or at other hospitals in Denmark.

The Board replied that they would consider if any action was needed and that I would not be informed about anything they did or didn't do, as I was not a "party to the case." So, no one knows if they ever did anything. So much for patient safety.

They told me to contact the Board of Patient Complaints, which I did, and they replied they wouldn't do anything. I then asked them for advice about which authority to contact when medically indefensible treatments take place. I thought they were obliged to do something because they wrote to me: "We handle complaints about health professional activity in the health service and the professional activity of health professionals."

But I had underestimated the power of bureaucracy. There always seems to be an excuse to turn a blind eye. I was told my complaint was out of date and that "Our decision is final. This means that you cannot complain to another authority about our rejection."

Isn't it unreasonable that a doctor who is concerned about the patients' well-being and survival cannot get any feedback about whether any authority in Denmark intends to do something? And if so, what the result is?

I therefore wrote to the Board for Patient Safety again. I wanted to know if they dealt with the matter and if not, where I should go.

A senior doctor from the Board replied that they regarded the conditions as obsolete and that they had no indications that the issues were still relevant in 2023. They had therefore closed the case. "Should you have knowledge of current patient procedures where similar conditions should factually apply, you are very welcome to contact us again after concrete and prior acceptance from the patient(s) in question. We will then assess the conditions again on a concrete and current basis."

This is unbelievable. They cannot know if Rigshospitalet continues to commit medical errors, as they have not investigated it. I find it likely, but how would I be able to investigate it? It would be easy to take a random sample of patients admitted to Rigshospitalet with stable angina pectoris to see what the department is doing.

I ended my article with: "Do something!"

## Transient cerebral ischaemia

In 2014, the letter "m" suddenly disappeared when I wrote on my computer, leaving only the white background. A little later, other letters disappeared, and a vertical line became a dotted line. As this looked like an attack of transient cerebral ischaemia (TCI), I phoned a

neurologist at Rigshospitalet who advised me to come immediately. I took my car, which was not particularly wise, given my condition.

Fifty minutes later, while patiently awaiting a neurologist, I tested my visual field. When I tested my left eye, it was as if a curtain was slowly being closed in front of it. I became blind in a matter of seconds, jumped out of my chair and grabbed a nurse saying that something needed to be done quickly. A neurologist came by a little later, and when she tested me, most of my vision had come back.

Another neurologist thought I suffered from paroxystic atrial fibrillation and wanted to start me on aspirin and dabigatran (Pradaxa). I told him I would not take Pradaxa because if I started bleeding, there was no antidote, in contrast to warfarin, a similar drug.

I also said I sometimes sprinted 100 m at full speed in the forest and drove as fast as I could on my racing bike. Therefore, I was worried about being anticoagulated because I might fall and get a head injury. He explained that Pradaxa was the recommended drug in their guidelines and tried to convince me to take it, arguing that warfarin was a rat poison that would never have been approved by the drug agencies if it had been discovered today.

He must have listened too much to salespeople from Boehringer Ingelheim, the maker of Pradaxa, or their paid allies among doctors, because this kind of speech is what you hear from unreliable sources. I told him it was a marketing trick to give doctors the false impression that, in contrast to warfarin, no monitoring was needed for dabigatran. As he didn't know this, I sent him a *BMJ* paper about it.[1973]

Even so, he tried hard to convince me to take Pradaxa referring to their guidelines. I was unmoved and phoned a colleague, a specialist in internal medicine. He agreed entirely with me. Two of his patients on Pradaxa had recently died!

When the neurologist looked at the notes from my last admission four years earlier with angina, he changed his mind about atrial fibrillation and now told me I should take aspirin and clopidogrel because of my TCI attack.

I went through a good deal of the relevant science during the 24 hours I spent at the hospital, which convinced me it was a bad idea to put me on both aspirin and clopidogrel. As an example, a review showed that treatment of 1,000 patients with the combination would spare 13 cardiovascular events while it would cause 6 major bleedings.[1974] Moreover, many of these patients had various risk factors. I had none.

A nurse put my head into an MR scanner but didn't tell me what would happen. There were very loud noises; sometimes my couch was shaking quite a bit; and there were long pauses. This oddity lasted 45 minutes and even then, I waited for a very long time while a doctor examined my results. I lost my patience and, with my head still in the magnet, I asked several times to find out when it would end but I was alone. I had a small balloon near my hand, an alarm I could press if I was in distress, but I was not alarmed.

Finally, the nurse came back. They needed to do more recordings. I said it was enough and that the doctor should make decisions based on what they had. I later asked what the purpose was. Well, if there were signs of earlier thromboses such as dead brain tissue, they would look more carefully for any possible source of the blood clots.

The routine was to monitor people's hearts for 48 hours, but the next day, I requested to leave the department because I was okay and needed to lecture in another town.

I came back two days later for an ultrasound of my neck arteries even though I had told the staff they wouldn't find any arteriosclerosis in them. As expected, they were smooth.

The last investigation was an echocardiography, but the chief physician and I agreed it would be a waste of time since one I had four years earlier was completely normal.

The scientific literature was not of much use because I had no risk factors. I told the chief physician that I was not interested in taking pills. We negotiated a little and I agreed to take baby aspirin for three months, but as the dose was much too large, I divided the 500 mg pills with a kitchen knife and took a small dose every day.

This episode taught me that it is difficult to practice evidence-based medicine. It is cook-book, or guideline, medicine, but patients are very different, and hospital doctors do not have enough time for individual decision-making. This causes a great deal of harm since, according to guidelines, everybody is treated the same way.

The most problematic patients are those who take many drugs. We don't have a clue about what will happen when we add more drugs on top of all the others. We only know that the risk of dying increases with the number of drugs we take.

Just prior to leaving the hospital, a nurse came into the room where I worked on my computer and measured the blood pressure. It was only 99/70. I told her it couldn't be correct because I had never had a blood pressure below 100. I suggested she tried my other arm. Now, it was 130/100. That couldn't be true either, but the nurse explained that blood pressures were not necessarily the same in both arms.

"I know," I said, "but there should not be such a great difference." I therefore asked to have my blood pressure measured on both arms in my hospital bed where they had a stationary apparatus. As expected, it was now the same in both arms and similar to the low level when I arrived, 118/76. I told the nurse they needed to check the mobile apparatus.

Please note how easy it is to get a diagnosis of hypertension that is wrong!

There were other surprises. The first neurologist said that my homocysteine was 20 and that the upper normal range only went to 15. She deduced that I might suffer from vitamin B12 deficiency. I told her not to worry. I was fine. She seemed to accept that. When I came home, I looked up homocysteine and found out that it is an unreliable indicator of anything and should therefore not be used as an indication that something is wrong.

The first neurologist told me that my MR scan had shown an aneurysm, but she added that this is quite common. I know. You cannot be subjected to an MR scan without a big risk of finding something fairly normal. That didn't worry me.

But it worried me a little that the nurse who scanned my neck arteries told me that one of them was quite twisted. I am quite sure I learned during my medical studies that this predisposes to blood clots in the arteries - mechanical obstructions causing turbulence. But if true, I can do nothing about it. Why inform me about something I cannot act upon, which can only make me anxious?

Like when I was admitted with angina four years earlier, no one knew what was wrong with me. Transient loss of vision can be caused by an embolus, but the chief physician suspected a thrombus in the occipital lobe because printed letters disappeared. How strange that I am such an odd person who continues to defy medical textbooks.

I left the hospital, put it all behind me, and made Brian McFerrin's refrain in the song "Don't worry, be happy," my motto. See the fabulously funny video on YouTube.

I looked up the recurrence risk for TCI and it was about 7%. A year later, I developed double vision that lasted half an hour, and three years later I suddenly got blurred vision, which lasted for about five minutes. I thought about taking aspirin again but didn't.

The staff at the Department of Neurology was excellent and very kind. But, as just noted, I could teach them a great deal, nonetheless. They must appreciate that most patients are easier than me.

## An overlooked ileus

My angina and TCI were handled at Rigshospitalet, my own hospital, the best in the country. When I developed ileus and ended up in a local hospital, Hillerød, I experienced what it means to be seen by totally incompetent doctors. They almost killed me.

Early one morning in 2015, I got stomach pain I didn't bother about. Then suddenly, an extremely strong pain ascended to my mouth which filled with saliva with a pronounced blood taste. I rushed to the toilet feeling so miserable that I genuinely thought I might die.

Seven years earlier, I had pain caused by kidney stones - described in textbooks as the most intense pain you can experience - but this was worse. I immediately suspected ileus.

Helle came home an hour later, and we listened to my stomach with a stethoscope. No bowel sounds. We both suspected ileus.

The pain came and went. In the afternoon, I ran 5 km in the woods alone, totally irresponsible but a sign of my never-failing optimism. Unlike other runs, I didn't pass gas. I didn't pass stools the whole day, and when I got equally violent attacks in the evening as those in the morning, we were both convinced it was ileus.

We phoned a surgeon at Rigshospitalet where we both worked who recommended an acute CT scan of my abdomen. However, I was obligated to go to Hillerød Hospital. I felt fine on arrival and was so certain about the diagnosis that I asked the nurse to cancel the routine blood tests explaining, "You cannot diagnose ileus in a blood test."

I just needed a CT scan. But a doctor declared two hours later that I didn't have ileus because I had bowel sounds, my abdomen was soft, and I appeared unaffected. However, ileus symptoms can come and go, in which case we call it subileus. I repeated that I had endured insanely strong intermittent pains, but he didn't listen. He had decided it wasn't ileus, even though I had not passed gas or stools all day. Yet in my file, he did not suggest any other diagnosis. I apologised for cancelling the blood tests, and he gave me the business card of a coordinator I could contact if I didn't get better. I was sent home.

The next day, I still had pain but passed some loose stools.

On the third day, I experienced strong abdominal pain during the night and excruciating pain attacks with saliva and blood taste next morning. I drove to the surgical department again and told the staff I was convinced I had ileus and was in very bad shape.

My pain attacks were so strong that I almost fainted. I contacted the staff several times and asked to be seen by a doctor. Several doctors entered my 8-person room during the morning, and one spoke to a man who was to be transferred to another hospital. I wondered why they took care of lesser issues before seeing a patient with acute abdominal pain that strongly suggested ileus. They continued with their minor tasks the entire morning. I felt I was being punished for having cancelled the blood tests two days earlier.

I sat down on a chair in the hallway to demonstrate my existence. More doctors came and went, and I told the nurses I didn't understand why they didn't attend a patient with acute abdominal pain. They knew I was a colleague but said the doctors made their own priorities. Really? At a department of gastrointestinal surgery nothing is more important than an acute abdomen.

Five hours after I had arrived, my desperation had turned to fury. I called Helle, and we agreed the situation was untenable and that I needed to go to Rigshospitalet. She called a senior colleague there, but he was busy.

I stopped a doctor in the corridor. I hid my rage and kindly said that they needed to see me because I was in a bad condition and probably had ileus. "A doctor will soon come," he said before walking away. That I was a colleague didn't matter to them.

Half an hour later, a doctor finally arrived. She was convinced I had gastroenteritis even though I emphasised that the extremely violent attacks of pain were incompatible with that diagnosis, and also that I didn't pass gas or stools, which excluded it. I explained that I had experience with gastrointestinal surgical patients and with infections. She wondered why the first doctor gave me a business card to the coordinator who could not help me because she took care of cancer patients.

I was sent home.

On the fourth day, I vomited explosively, which is a key characteristic of ileus. Helle was deeply concerned and said they should have ordered a CT scan. I was totally miserable. I laid on my stomach and could not sleep because of the intense pain.

I was told at Hillerød to see my doctor if I did not improve. He suspected gallstones and wanted to send me to Hillerød for an ultrasound, which I refused. Under no circumstances would I go back to a hospital where they do not take patient complaints seriously. Then he sent me to Herlev Hospital where no gallstones were found on ultrasound.

A chief physician, Thomas Boel, arrived and immediately ordered an emergency CT scan. It showed a 30 cm long invagination of the large intestine into itself. Boel consulted with a colleague, and they agreed to remove most of my large intestine the next day, because it was too late in the day. I noted several times how crippling that operation would be and asked if less might suffice.

I read articles about invagination in adults online. They all recommended to remove the intestine in its entirety, which has to do with the blood supply. I was forewarned that I might wake up with a pouch on my belly for the stools.

The following morning, half an hour before the operation, I passed normal stools for the first time in a week. If I had not been a doctor, I would have been operated on, but I knew my condition was improving, got out of bed, and told the nurses and Boel about it.

The porter came but was asked to wait because the doctors would discuss my case at their morning conference. A little later, Boel told me that the radiologists had spotted a 5 cm tumour in the transverse colon, which appeared to be a lipoma, causing my ileus. They would try to remove it with a coloscope, so I could preserve my intestine.

The discussion had been intense. Some had wanted to remove my colon, while others wanted to be conservative. I should have participated. It was my life and colon, and I was a colleague. I would have said that, since they were in doubt, they must be conservative.

There was so much oedema in the intestinal wall that they dared not remove the tumour immediately with a coloscope. And they did not have a sling that was big enough to be passed around the tumour to burn its stem.

My incredible luck continued. The pain and the palpable tumour in my abdomen went away, which meant that the invagination had straightened itself out. I became dead hungry and had a real meal for the first time in a week.

The doctors would get a bigger sling from the manufacturer, but the intestinal wall would need to go back to normal before they could use it. I was very worried the ileus might come back, and that the colon would be removed anyway. I suggested a rewrite of the textbooks. You should always do a colonoscopy before deciding to remove a large portion of a healthy colon. Boel agreed.

I got an appointment for tumour removal four weeks later but could not wait that long. Immediately after that date, I would be chairing an important international meeting in Copenhagen I had arranged and, if anything went wrong, I would not be able to do so. Therefore, I asked for a date only three weeks later. The meeting was related to the launch of my first psychiatry book,[1975] and it meant so much to me that I recorded my talks at home on video, so that they could be played at the meeting in case I became incapacitated or died.

I was lucky again. If I had not advanced the date, the ileus would likely have come back. The surgeon could not get the sling around the tumour and put two rubber bands around the stem instead so it would die and be passed with the stools after 2-5 days. The pain came back already the next day and gradually became worse. One of the surgeons had told me that if I got ileus again, they might be able to blow my intestine back with a coloscope. That was also what I thought. In the evening before the planned removal of my colon, I asked a senior surgeon if they could straighten out my colon instead of removing it. He said no, but maybe they could. Invagination is very rare in adults and since surgeons have no experience with it, they choose the most drastic solution because ileus is life-threatening.

It was now a fight against the clock. Four days later it was worst. I drank a lot and ate only soup hoping it would make it easier for the stools to get past my subileus.

I made it just in time. Six days after the rubber bands were put in place, the tumour came out. It was strange to see a nasty, repulsive piece of yourself. I washed it and cut through it. It was white inside but more varied with bleedings on the periphery.

I was worried it might be malignant after all, even though a biopsy had ruled that out four weeks previously. Microscopies can overlook a cancer, and large colon tumours in people my age are almost always malignant. But, as was also the case with my angina and TCI, I was not like other patients.

Two weeks later, a TV documentary about the gastrointestinal surgical department at Hvidovre Hospital was broadcast.[1976] A patient was seen by 21 different doctors in 17 days without getting a diagnosis. He then went to a private hospital where it took only 20 minutes to give him the correct diagnosis: gallstones in the bladder and bile duct. He had a life-threatening infection with staphylococci.[1977]

The patient was a journalist, and he was so shocked about what he experienced during his hospitalisation that he made secret recordings on his iPhone. They showed that the doctors changed their explanations to cover up for their mistakes.

The case was reported to the Patient Safety Board, which criticised Hvidovre Hospital for being too slow at initiating relevant investigations. The journalist received an apology from the hospital director, but not for overlooking a life-threatening infection, only for minor things such as consultations in the hallways and inadequate cleaning. With a $40^0$ fever and sepsis, the journalist had staggered up from his hospital bed and had documented that old stools still remained on the edge of the toilet seat, and that there was still urine on the floor, after the cleaning assistant had left the toilet.

The documentary ended by encouraging patients with similarly bad experiences to get in contact. Since I was deeply shaken by my experiences, I sent an email and was interviewed in the news.[1978] I hoped that, by telling my story, I might save lives. The journalists were totally on my side. For them it was scandalous that a professor of medicine with years of clinical experience could spend many hours in a hospital with a life-threatening condition without being able to see a doctor.

It also profoundly disturbed them that my symptoms were ignored, even though I had years of experience from the relevant specialties. Further, Helle was an experienced chief physician who taught medical students about gastrointestinal infections, and we both knew I did not have gastroenteritis but ileus.

I explained on TV that ileus requires an urgent operation and has a mortality rate of about 16%: "The longer you have ileus, the worse it gets. The intestine becomes vulnerable, and if bacteria slip through the intestinal wall and infect the abdominal cavity, one third of the patients die. So, I was in a very dangerous condition. I felt very lonely and knew I might die because I've seen many people die on gastrointestinal surgery and medicine wards. It is not amusing to be in that situation and, on top of that, feel a lack of medical expertise."

Filing a complaint is usually futile but I did so for the sake of future patients. I wrote to Hillerød Hospital that I found it remarkable that, even though I had repeatedly told the doctors about my incredibly strong pain, nothing was stated about that pain or its severity in my record. One doctor wrote about a mild "heartburn," but at no point in time did I mention reflux or heartburn, and the pain was very severe.

Furthermore, I noted that in all the departments where I had worked, we always took the nurses seriously, and if a nurse said a patient was in poor condition and should be seen by a doctor, we always did that. The fact that none of the nurses asked a doctor to see me - or if they did the doctors ignored their request - was a testimony of a sick department culture that could be dangerous for the patients.

I noted that during six days, I ate almost nothing, which does not suggest gastroenteritis, and that my very strong and unusual symptoms were not taken seriously at any time:

"The vast majority of serious medical and surgical conditions fluctuate in intensity, and the patient can often appear unaffected. Those kinds of ‘snapshots’ must not lead doctors to believe and maintain that it's probably not as bad as the patient says it is, yet that was exactly what happened … It's totally unacceptable to let a patient wait for five hours, especially when that patient is a professional and shows up with an acute abdomen … plenty of doctors were at work that Sunday ... There is a sick culture in the department which must be radically changed. Allow me to remind you that ileus is a life-threatening condition."

The hospital did not address my criticism. I received an elusive answer stating that the quality of the treatment I had been offered could not be doubted!

Patients can forgive a great deal if they get an apology. But administrators do not understand that. They never apologise for anything unless they are under severe pressure, as in the case with the journalist. Not a trace of an apology was found in the letter I received. This makes people angry.

I then complained to the Patient Safety Board. It took a year and a half to get a reply. Yes, eighteen months! The board unequivocally cleared Hillerød Hospital of any wrongdoing. It was only then I saw the full extent of the serious errors in my records, because the hospital sent them along with its report to the board.

The records said that the doctor and I allegedly did not find "any great suspicion of a fulminant ileus condition, and hence we agree" that I could be sent home. That was a lie. I never abandoned my suspicion of ileus, and I did not want to go home.

The worst part was a statement from Henrik Stig Jørgensen, chief surgeon at the department. He was very curious as to why a senior surgeon at Rigshospitalet where I worked recommended an acute CT scan after only speaking to me on the phone. How could a doctor at Rigshospitalet make a diagnosis over the phone, which a doctor couldn’t make at a physical examination at his hospital, he asked.

These remarks smell of professional jealousy. You should not think you are important just because you are a professor and work at Rigshospitalet.

Contrary to Jørgensen's claim, the surgeon at Rigshospitalet did not make a diagnosis but advised a highly relevant diagnostic test. Jørgensen also ignored that Helle and I are doctors and had made the physical examination he wanted. And he ignored that my condition fluctuated, which is inexcusable for a person in his position. His arrogance was pronounced. I had signed my letter to the Patient Safety Board with my full title. Although Jørgensen's letter was only two pages long, he referred to me 17 times with my full title, e.g.: "The staff and the senior surgeon perceived Professor, chief physician, DrMedSci and MSc Peter Christian Gøtzsche as impatient, sitting in the hallway. It is correct that 5 hours is a long wait, but Professor, chief physician, DrMedSci and MSc Peter Christian Gøtzsche was actually prioritised over other patients."

This was a huge lie. Furthermore, Jørgensen's remark that, "It is the senior surgeon's clear perception that they agreed there was no sign of serious illness" is also blatantly dishonest. I was seriously ill but the surgeon wrote in my records that she thought I had gastroenteritis.

One of the first diagnoses I ever made as a medical student was ileus in an old lady who complained of stomach pain. I made the diagnosis with my hands and stethoscope. The chief physician was so impressed that he offered me a job when I had passed my medical exams, which became my first job as a doctor.

Jørgensen ended his letter by saying that the leadership in no way believed the department had a sick culture. Evaluating yourself is not credible and he demonstrated the opposite in his letter. It takes a sick culture to trample on a patient who is already lying down and is worried he might die from a serious illness he has diagnosed himself but which the department ignored. Several of my family members have had horrific experiences at this very department.

There are several things to be learned from my case:

Doctors must never modify what the patient says to better fit with what they believe the illness is, and they must never write about non-existing symptoms in the patient's records, which happened in my case. If it happens in science, we call it fraud.

We cannot trust patient records. They have often been changed when physicians get in trouble. It can be a good idea to ask for the doctor's notes early on, so that you can request amendments if needed. In my case, the false information about heartburn was repeated by the Patient Safety Board when it cleared the hospital for any wrongdoing.

A hidden camera or microphone is sometimes necessary because doctors may lie to cover up for themselves or their colleagues.

Patients should be allowed to participate in conferences where doctors discuss possible diagnoses, tests and treatments related to them. This may seem a radical proposal but it isn't.

## My fight against a polar bear and other minor issues

"How did it happen?"

"I tried to defend myself by kicking out at a polar bear that tried to kill me. I am convinced I broke my second toe on the right foot."

I have lively dreams, so my description of why I broke a toe was correct. My kick was stopped by the bedroom wall.

I have also broken a finger and my right arm twice at the tennis court. I am often amused by all the suggestions I get from my fellow players when I develop a painful tennis elbow. They have suggested physiotherapy, chiropractic, injections, and ultrasound. The only thing that works is to rest your elbow. Pain is an important signal that has helped us survive throughout evolution. When something hurts after an injury, it is a warning about letting that body part rest until it heals.

When I was young, I had several ankle distortions within a short time period after falls on the tennis court, and I was offered an operation to shorten the ligaments. When the operation date was approaching, I asked the surgeon at Frederiksberg Hospital what could go wrong and how often this happened. He became very insulted that I could question his surgical capability and told me that if I didn't want the operation, he would cancel it. He never replied to my questions, and I became so suspicious because of his arrogance and rude treatment of me that I cancelled the operation.

Six months later, the ligaments had retracted by themselves, and I did not get any more ankle distortions.

When I lectured for specialists doing ankle operations some years later and told them about this, they immediately exclaimed: "Who was this surgeon? It virtually always goes wrong!"

This is an appropriate way to end my autobiography. Many things in healthcare can go wrong or are simply wrong to begin with. You therefore need to investigate for yourself, if you can, if what health professionals want to do is a good idea.

But before I stop, a little note about lucky numbers. When I was a teenager, I learned that an actress had chosen 13 as her lucky number as a protest because so many people are superstitious that the 13$^{th}$ floor is often missing in American hotels. As I was born on 26 November, which is two times 13, I thought: great, I will pick that number, too.

Funnily, the most decisive events in my life happened on the 13$^{th}$. I opened the Nordic Cochrane Centre at a meeting on 13 October 1993; saw my wife Helle for the first time on 13 April 1994; planned to marry her on 13 May 1994, which was the only available date in Domus Medica at that time of the year and we had planned to have our wedding dinner there, but we moved it forward to 11 February 1994 because we had bought a house together, and 11 +2 = 13; and I was kicked out of Cochrane on 13 September 2018. Perhaps I shall die on the 13$^{th}$, too, but will not live to tell people about it.

# 19 Recent events

For the historical record, and to make it easier for historians to work with some of the issues I have contributed to, I have made an electronic archive of my publications in medical journals, newspapers and on websites. I have also downloaded TV and radio interviews and documentary films. The Royal Library in Denmark has offered to provide archiving space but only for material on paper, which is anachronistic. I shall therefore establish an open archive elsewhere, which will be easy to locate under the name *The Peter C Gøtzsche Archive*.

## Journal of the Academy of Public Health

In late 2024, Martin Kulldorff rang me about a new journal he and Jay Bhattacharya would be launching, the *Journal of the Academy of Public Health (JAPH)*. He asked if I would join them as an editorial board member.[1979] As this was exactly the kind of journal we so much needed, I enthusiastically accepted.

The main idea is to avoid the pervasive censorship in traditional medical journals, which is usually related to financial, guild, or other interests. Highly relevant criticism of published research is often impossible to get accepted in the same journal, particularly if you demonstrate that the study is fatally flawed, and if accepted, there is too little space for it, in a letter to the editor.

A main asset of the new journal is that it allows such criticism (up to 2000 words). The original authors will be given an opportunity to respond, and the critic will be allowed a short rejoinder. I criticised two terribly flawed articles in early 2025, one that claimed that vaccines cause autism,[1980] and one whose authors used invalid arguments to dismiss their clear finding that the most toxic neuroleptic, clozapine, was not any better than other drugs for schizophrenia (see page 162 for details about this research).[1981] In both cases, the authors failed to address my substantial criticisms and talked about something else[1982] (their replies and my replies can be found under the tab Peer Reviews). I believe these two articles and subsequent discussion illustrate how important *JAPH* is.

Articles are open access, and thanks to financial support from the RealClear Foundation, there is no fee for publishing a criticism of published research. There is a fee of $500 or $2000 for other types of articles.

To keep the workload at a reasonable level, only members of the Academy can submit articles and publish in the journal. Editorial board members can invite others for membership who will then be assessed for their scientific rigorousness by the editors.

The journal was launched on 5 February 2025 and only two days later, it was heavily criticised in *Science Magazine*. A scientist I had recommended as a member of our Academy said that the fact that *Science* feared our new journal suggested that we were on the right track. The criticism was grossly inappropriate and *ad hominem*, too, which I explained in an article where I reminded people how consistently wrong and biased *Science* was during the COVID-19 pandemic.[1983] In the *Science* article, Kulldorff said that people had a right to be worried about what might happen with our new journal but that it should be judged on its output a year or more from now, once it's more established.

In the first issue of *JAPH*, I published the article, *Forced treatment in psychiatry is a crime against humanity*.[1984] and Martin explained why our journal is important in a very interesting article, *The rise and fall of scientific journals and a way forward*.[1985]

## America is in deep crisis

In the autumn of 2024, I warned against voting for Trump in numerous tweets (@PGtzsche1) and I summarised some of them in an article after he had been elected.[1986] Trump's slogan, Make America Great Again (MAGA), is misleading because it was so obvious that what he wanted was to make himself greater and a dictator.

Trump's rhetoric is very primitive and speaks to the lowest instincts in those with the lowest intelligence, and history has shown how dangerous this gossip-like simplification of political matters is. His speeches are full of hate and grandiosity and much of what he says comes very close to what Hitler and Mussolini said, e.g. "We pledge to you that we will root out the communists, Marxists, fascists and the radical left thugs that live like vermin within the confines of our country that lie and steal and cheat on elections" and "Please just deploy the military and take control of these animals who are ruining our cities!" Both Mussolini and Trump said they would "drain the swamp and clean up the country" and Trump said that immigrants were poisoning the blood of America, very similar to what Goebbels said about the Jews.

Worst of all, he wants to buy Greenland, a sovereign country and NATO ally, or take it by military force. His Vice President, JD Vance, said before Trump picked him that Trump might be America's Hitler. He constantly lies about how badly Denmark has treated the Greenlanders and tries to convince them that they should become Americans. How was it America treated their Indians? Murdered by far most of them and killed their livelihood, the buffalos, and violated virtually every treaty they entered with them.

We have seen disaster upon disaster, almost daily, harming not only America but the whole world. Already on his first day in office, Trump made USA a banana republic by pardoning over 1500 Capitol rioters. Trump thinks he is above the law, as all dictators think.

The world's richest man, Elon Musk, was tasked with reducing the federal work force drastically and swung a chainsaw on stage to the cheers of the crowd.[1987] If what the Trump administration is doing had been a satirical movie, the critics would have said that the plot went too far, this couldn't possibly happen. But it did. This is America in 2025 and four more years.

America is in deep crisis and a satire on what democracy should look like. When Robert F Kennedy Jr. was nominated as the new secretary of health, Marty Makary as the new FDA commissioner, and Jay Bhattacharya as the new director of the NIH, the legacy media and *Science Magazine* attempted character assassination on all three instead on focusing on the widespread corruption, the dysfunctional and way too expensive healthcare, and what the nominees wanted to do and might accomplish in their new roles.[1988] We can only hope that they will get some success.

## About the author

I graduated as a Master of Science in biology and chemistry in 1974 and as a physician in 1984. I am a specialist in internal medicine, worked with clinical trials and regulatory affairs in the drug industry 1975-1983, and at hospitals in Copenhagen 1984-95.

I co-founded the Cochrane Collaboration and established the Nordic Cochrane Centre in 1993, became professor of Clinical Research Design and Analysis in 2010 at the University of Copenhagen, co-founded Council for Evidence-based Psychiatry in the UK in 2014 and the International Institute for Psychiatric Drug Withdrawal in Sweden in 2016, and founded the Institute for Scientific Freedom in 2019.

I am officially retired but work full-time writing scientific articles and books, as an expert witness in lawsuits, and with filmmaking. I do sports every day but Mondays.

My greatest contribution to public health was when I opened the archives in the European Medicines Agency in 2010 and got access to the clinical study reports of drugs after a three-year long battle that involved a complaint to the European Ombudsman. The agency was solely concerned with protecting the drug industry's interests while ignoring those of the patients.

I have published over 100 papers in "the big five" (*BMJ*, *Lancet*, *JAMA*, *Annals of Internal Medicine* and *New England Journal of Medicine*) and my scientific works have been cited over 150,000 times. My H-index is 91 according to Web of Science (June 2023), which means that 91 of my papers have been cited at least 91 times. I am author of several books:

How Merck and drug regulators hid serious harms of the HPV vaccines (2025, in press).
Is psychiatry a crime against humanity? (2024, in 2 languages)
Critical psychiatry textbook (2022, in 2 languages).
The Chinese virus: Killed millions and scientific freedom (2022).
Mental health survival kit and withdrawal from psychiatric drugs: a user's guide (2022, in 7 languages).
The decline and fall of the Cochrane empire (2022)
Vaccines: truth, lies and controversy (2021, in 7 languages).
Survival in an overmedicated world: Find the evidence yourself (2019, in 7 languages).
Death of a whistleblower and Cochrane's moral collapse (2019).
Deadly psychiatry and organised denial (2015, in 9 languages).
Deadly medicines and organised crime: How big pharma has corrupted health care (2013, in 18 languages). Winner, British Medical Association's Annual Book Award, Basis of Medicine, in 2014.
Mammography screening: truth, lies and controversy (2012). Winner of the Prescrire Prize in 2012.
Rational diagnosis and treatment: evidence-based clinical decision-making (2007).
På safari i Kenya (1985).

I have given numerous interviews, one of which - about organised crime in the drug industry - has been seen by over a million people on YouTube. I was in The Daily Show in New York on 16 Sept 2014 where I played the role of Deep Throat revealing secrets about big pharma.

A documentary film about my reform work in psychiatry, Diagnosing Psychiatry, appeared in 2017, and another one, with the working title, *The honest professor and the fall of the*

*Cochrane empire*, about the moral collapse of the Cochrane Collaboration, is in production. Donations to the film can be given here.

I have an interest in statistics and research methodology and have co-authored guidelines for good reporting: CONSORT for randomised trials, STROBE for observational studies, PRISMA for systematic reviews and meta-analyses, and SPIRIT for trial protocols. I was an editor in the Cochrane Methodology Review Group 1997-2014.

I am Protector for the Hearing Voices Network in Denmark.

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