

GUEST COLUMN:
**ON THE NECESSITY OF MEDICAL DOCUMENTS IN CLAIMS
OF PARANORMAL PHENOMENA IN DISEASES**

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I believe in miraculous healings. By this I mean I am confident that a small number of patients with grave illnesses — ones that are ordinarily fatal—have made unexpected recoveries. I use the word *miraculous* to accentuate the unexpectedness of their recoveries, not to imply a supernatural explanation for them. We can say that such recoveries are, as David Hume wrote: “a violation of the laws of nature” (Hume, 1748/1985, p.30). What Hume described as “the laws of nature,” however, are declared such by humans just as much as are our laws against crimes. Our understanding of these “laws” has evolved since Hume’s day. This Society and its journal exist because its members believe further scientific endeavors will show us presently unknown processes of nature; these will lead to our amending our concepts of “the laws of nature.” Miraculous medical phenomena hint at a coming change in our understanding of health and disease.

The general public has become increasingly aware that unexpected recoveries from ordinarily fatal illnesses, although rare, do occur. O’Regan and Hirshberg (1993) compiled an immense bibliography of reports published in medical journals of documented unexpected “remissions” from grave illnesses. Persons who suffer from such an illness — or observe one in a person they love — hope, and often pray, for such an unexpected recovery.

A first requirement of reports of unexpected medical phenomena is reliable, objective knowledge about the nature of the disease from which the patient was suffering. West (1957) examined the records of eleven patients who were said to have made unexpected recoveries after going to the shrine of Lourdes in southern France. He concluded that not a single one of the medical records of these cases warranted the diagnosis of a grave and presumably fatal or at least irremediable illness. When my colleagues and I examined relevant medical records, we learned that about half the patients who had reported to us that they had been near death from illness or injury were not in fact close to death (although they thought they were) (Stevenson, Cook, & McClean-Rice, 1989-90; Owens, Cook, & Stevenson, 1990).

Since the time of West’s investigation standards of acceptance of an unexpected recovery at Lourdes have improved (Dowling, 1984). Certainly a few such recoveries *are* well documented. For example, Salmon (1971, 1972) reported a patient’s recovery (after a journey to Lourdes) from a sarcoma of the

pelvis that was diagnosed histologically (by a biopsy) as well as radiologically. Chauvin (1991) reported another unexpected recovery at Lourdes, this one from an enormous bleeding fibroma of the uterus that impeded the patient's absorption of food and brought her to a condition of prostration. Chauvin was able to study verifying medical records in this case.

What is known as the "placebo effect" might shed some light on unexpected recoveries. A placebo is a pharmacologically inert substance the taking of which modifies the course of an illness. The effect is due to an alteration in the patient's belief about his or her body, including its illness. The effect can be considerable; for example, in five separate studies of the placebo effect, psychiatric patients showed on average a 50% reduction in their symptoms (Gliedman *et al.*, 1958). Improvements related to change in belief — call it faith if you prefer — do not require the administration of a pill. Confidence of the patient in the physician or in any procedure the physician performs or recommends may suffice.

An immense literature has developed from investigations of the placebo effect. Unfortunately, most of it derives from studies of psychiatric patients or patients with conditions known to be at least partly caused by psychological factors. Few investigators have studied the influence of faith on serious life-threatening illnesses. A German gastroenterologist, Hans Rehder of Hamburg, conducted an experiment neatly designed to show this influence (Rehder, 1955). The subjects were three female patients, all bedridden with severe intractable illnesses that had not responded to standard treatments. One patient had chronic cholecystitis (inflammation of the gallbladder) with repeated attacks of biliary colic (pain from gallstones jammed in the bile duct); she was in constant pain and had some fever. An operation seemed inevitable for her. The second patient suffered from intestinal obstructions due to adhesions that had formed in her abdomen after an operation; she was in almost continuous pain and unable to have normal bowel movements. She had lost weight to the point of being emaciated, and her condition seemed desperate. The third patient had widespread abdominal cancer from a primary, inoperable source in her uterus. She was severely anemic and had edema (marked accumulation of fluid) of the legs and ascites (accumulation of fluid in her abdomen).

Rehder had become well acquainted with a "spirit healer" called Trampler, who lived near Munich. Trampler believed that he could act as a channel to direct the healing power of God to patients who were ill; he was confident he could heal patients at a distance. He had written a booklet about his methods entitled "Healing through the Spirit." When Rehder told him about his three hopelessly ill patients, Trampler offered to heal them. Rehder agreed. They set dates and times when Trampler would send his "distant healing." Rehder told the patients nothing about this endeavor. At the agreed on dates and times Trampler carried out his program of "distant healing" for the three patients. There was absolutely no change in their conditions.

Rehder then undertook a reverse experiment. He spoke with the patients in-

dividually — their beds were in different rooms and they did not communicate with each other — about miraculous healings at Lourdes and other similar sites of renowned healing. He prepared the patients thoroughly to expect a complete healing. Finally, he gave each of them a copy of Trampler's booklet, "Healing through the Spirit." Then he set exact dates and times — on three successive days — when they were to receive "distant healing" from Trampler. He carefully chose times when he knew that Trampler would *not* be engaged in any healing activity. The results were in Rehder's word "astounding." Almost immediately after the beginning of the nonexistent "distant healing" the patients showed dramatic improvement. The patient with painful gallbladder disease became free of pain, and her temperature fell. She got up, gained weight, declared herself entirely well, and was discharged within less than three weeks of the "distant healing." The second patient, with intestinal obstruction, also got out of bed and remained so. Her bowel movements became normal, her appetite returned, and she gained 30 pounds in weight. She felt entirely well and returned to work. The third patient, with widespread cancer and fluid retention, suddenly passed 9 liters of fluid in her urine, so that her legs and abdomen were no longer swollen; her appetite returned and her anemia improved. She believed herself well and looked as if she were. She insisted on being discharged and was allowed to go home. Although the second patient remained well up to the time of Rehder's publication, the patient with gallbladder disease eventually had to be operated upon; and the patient with cancer died several months after her discharge. Rehder made three other endeavors with similarly severely ill patients and reported one failure and two more successes. Rehder attributed the successes to his careful mobilization of the patients' belief, their faith, that they would be healed.

Accounts of cases of unexpected or miraculous healings or other unusual medical phenomena sometimes appear in popular books or provide material for sensational autobiographies. As examples, I will summarize three accounts in books written for general readers. One included adequate medical reports and two did not.

The first book (Hickey & Smith, 1978) describes the unexpected recovery of John Fagan, a docker of Scotland, from a cancer of the stomach that had invaded his colon and adjacent lymph glands. The surgeon, after an operation to remove the tumor, doubted whether he had been able to take it all out. The operation took place on May 26, 1965. Fagan at first seemed to do well, but then relapsed. A large swelling appeared in his abdomen; he gradually became weaker and finally moribund. It was generally assumed that tumor cells that had not been removed during the operation in 1965 had proliferated and produced the swelling in Fagan's abdomen and other symptoms of his illness.

Fagan was a Roman Catholic, and in January 1967 his condition seemed so desperate that his priest thought he should administer the last rites to him. At the same time the priest gave Fagan a medal of a well-known Catholic martyr. This was John Ogilvie, a Scot of the 17th century, who had converted from

Calvinism to Catholicism while studying on the Continent. He had then returned to Scotland in an endeavor to bring Scotland back to the Roman Catholic Church. He was arrested, given a summary trial, and executed in Glasgow in 1615. Ogilvie died with extraordinary steadfastness and composure. He became venerated among Scottish Catholics, and a movement for his canonization developed. In 1929 Ogilvie was declared "Blessed," a step on the way to being admitted to sainthood. In addition to the medal of Ogilvie given to Fagan, some members of the community who knew of his condition prayed for the intercession of Blessed John Ogilvie on his behalf. Contrary to medical expectation, Fagan began to vomit enormous amounts of purulent, malodorous matter. The swelling in his abdomen receded, his appetite returned, and by March of 1967 he was obviously recovering. By May 1967 he seemed to have fully recovered, and he remained well thereafter.

Such an unexpected recovery was understandably attributed to the intervention of Blessed John Ogilvie, and it led to an acceleration of the process for his canonization. This in turn required medical testimony as to the miraculousness (in medical terms, the complete unexpectedness) of Fagan's recovery. The physicians concerned with his care, and the consultant physicians called in to give their opinions, all, with one exception, concurred in declaring the recovery both unexpected and inexplicable. The dissenter was a gastroenterologist who believed it probable that Fagan had had a slowly developing abscess of the peritoneum, which discharged into the stomach, so that Fagan expelled its contents in his vomitus; the residue of the abscess then healed up. Another consultant gastroenterologist disagreed and sided with the majority of the other physicians, who favored the interpretation that Fagan had recovered unexpectedly from a renewed growth of his original cancer. The Roman Catholic clergy involved accepted the majority opinion of the panel of physicians; they believed that Fagan had recovered miraculously through the intercession of Blessed John Ogilvie. After the usual further procedures Pope Paul VI, in 1976, at a splendid ceremony in Rome, declared Ogilvie a saint.

Although the book by Hickey and Smith, which is my only source for information on this case, is written for general readers, it contains fully adequate summaries and extracts of the medical testimony in the case, including the opinions of the two disagreeing gastroenterologists. Anyone who favors the interpretation that Fagan had a spontaneously discharging abscess of the peritoneum, which I do myself, cannot charge that any relevant information has been withheld.

My information about the second case also comes from a single book, the autobiography of an English patient, Jennifer Rees Larcombe (Larcombe, 1991). At the age of 39, in 1982, Mrs. Larcombe suddenly developed persistent, severe pain in her head, neck, and spine; she became easily tired and extremely weak. A doctor examined her and thought she should be admitted to a hospital. There, she wrote, she was told that she had "encephalitis." At some point this diagnosis became modified, again according to Mrs. Larcombe, to

"myalgic encephalomyelitis." She failed to improve and was considered chronically and irremediably ill. Consultants of the British National Health Service awarded her the maximum disability allowance. She was given an apparently unlimited prescription for morphine tablets to relieve her pain. She purchased a motorized wheelchair and had an elevator installed in her house so that she could reach its second floor without having to be carried up the stairs. Her disability naturally disrupted her family life, but her husband and children, and the patient herself, adapted remarkably well to their changed circumstances. During eight years of this illness, Mrs. Larcombe never lost the hope that she would eventually recover, even though — from her account — the doctors thought she would not. A strong Christian faith led her to believe in miraculous healings, and she spent some time at a well-known healing center, Burrswood. This center had been founded by Dorothy Kerin, who herself had undergone a rapid, unexpected recovery from a serious illness. In the summer of 1990 Mrs. Larcombe became even more than usually confident that she would recover. On June 30, 1990 she went to a church, where at her request a young woman she had not met before placed her hands on Mrs. Larcombe's head and prayed to Jesus Christ, asking Him to make her well. Almost immediately afterward Mrs. Larcombe stood up, having been instantly healed. She remained well thereafter.

We have no reason to question the suddenness and unexpectedness of Mrs. Larcombe's recovery. It is possible, however, that she did not have encephalitis. As for "myalgic encephalomyelitis," this term has been applied to a heterogeneous group of patients with chronic fatigue for whose illnesses a viral etiology has been proposed but seldom confirmed. The symptoms of chronic fatigue and lack of energy sometimes occur after a viral infection, but this does not mean that they are due to a persistence of the viral infection (Kendell, 1991). A substantial number of patients with chronic fatigue have symptoms of depression, which may not be recognized as such. In the United Kingdom, in the 1980s and later, many persons with chronic fatigue learned of the diagnosis of "myalgic encephalomyelitis" and applied it to themselves (Leitch, 1995). Mrs. Larcombe wrote that her condition "was labelled by the neurologists as myalgic encephalomyelitis" (p.7), but she did not tell us who they were or quote them directly. It is possible that she overheard the doctors using words like "encephalitis" and "myalgic encephalomyelitis" — perhaps while they were just musing aloud about possible diagnoses — and adopted them as adequately explanatory of her condition. Hart (1954) queried ten doctors about monitory, pessimistic statements that patients with cardiac neuroses had attributed to them; not a single one of the physicians had made the statements quoted by the patients. Some of the patients in our studies (mentioned above) who believed they were near death when they were not may have similarly misinterpreted remarks that doctors and nurses had made in their presence.

If Mrs. Larcombe did not have some form of encephalitis, the most likely alternative diagnosis would be a somatoform disorder (formerly called "hyste-

ria”), with pain and muscular weakness the predominant symptoms. To this may have been added an addiction to morphine. On the way back from her disability, Mrs. Larcombe’s strong faith may have enabled her first to attenuate the amount of morphine she was taking and then have prepared her for a sudden shift in her belief about her body so that, believing she could walk, she did so.

The symptoms Mrs. Larcombe described (including their long duration) are compatible with a somatoform disorder. They are, however, equally compatible with residual symptoms of a viral encephalitis, which may also have a prolonged course; in one series of 39 patients, only 5 (13%) had completely recovered six years after becoming ill (Sigurdsson & Gudmundsson, 1956).

The absence of medical documentation in Mrs. Larcombe’s case deprives us of the opportunity to learn something more about the power of faith in healing. Somatoform illnesses are maladies of the mind, not of the brain or any other physical organ. (Here I write as a dualist regarding the mind/brain problem; most neuroscientists would disagree with me.) In contrast, encephalitis is a serious disease of the central nervous system. It would be helpful to have assurance that faith can heal it.

Mrs. Larcombe did not explain in her book why she did not include any reports from the several physicians who examined her. Perhaps satisfied with her own interpretation of her recovery — that it was due to faith and prayer — she may have thought medical documentation otiose. She may have been too timid to ask one of the physicians to contribute a statement for her book. Or she may have asked and had her request declined; not many physicians today are willing to be identified with claims of unexpected healings, often called miraculous. I find it puzzling that Mrs. Larcombe dedicated her book, in part, to her family doctor, and yet the book contains no statement from him. Whatever the explanation, Mrs. Larcombe’s book is not as helpful to medicine as it might have been with medical documentation.

My information about the third case, that of Betty Eadie, derives mainly from her autobiographical account of experiences that she said occurred when she was “dead” (Eadie with Taylor, 1992). She wrote that, following a surgical operation, she died, left her physical body and went to a heavenly realm. There she met and had long conversations with Jesus and unidentified “guides,” who explained the meaning of life and death to her. After being thus instructed, she returned to her body and recovered. This experience happened in 1973, almost twenty years before Eadie published her account of it. By this time numerous popular books about experiences near death had claimed that persons having such experiences had gained a knowledge of what life is like after death. The title of the first and best-known of these popular books, *Life After Life* (Moody, 1975), implies as much. Given the assumption that experiences near death provide the knowledge that death itself does, persons claiming to have obtained such knowledge only gain a receptive audience when they are able to assert that they were near death or, preferably, actually dead.

Eadie claimed that she died but nevertheless recovered. She did not, however, furnish any medical documentation of this, and the account she gave of her physical condition is implausible. She wrote that she underwent a hysterectomy and that during the following evening she hemorrhaged severely and died. According to her account, she had been left unattended in her room and so did not know how long she had been dead. After reviving she slept for perhaps four hours. She later learned that doctors and nurses “worked on me” through the next morning, but she claimed to have been unaware of this at the time.

Eadie’s account of her condition makes no sense in medical terms. If she had hemorrhaged following her operation to such an extent that she had died, or even had nearly died, the hemorrhage would almost certainly have required a return to the operating room so that the bleeding vessel or vessels could be properly tied to stop the hemorrhage. Eadie and her family would certainly have known about this. Eadie has repeatedly declined to allow her medical records to be examined, and she has at different times given different reasons for her refusal (Abanes, 1995). Her failure to provide medical documentation of her claim to have died makes her vulnerable to the charge that she needed the cachet of being dead in order to authenticate her statements about life after death. Given that (in our investigations of near-death experiences) as many as 50 percent of persons believed they were near death when — judged by their medical records — they were not, Eadie’s claim to have been dead is worthless. One cannot declare oneself to have died; if death occurs, a qualified other person must say so.

Of what interest, readers may ask, are the merits and deficiencies of three popular books to the scientists who read this journal? There are three reasons for such interest. First, the distinction between popular (and hence often untrustworthy) books and scholarly or scientific ones is as blurred in the field of medicine as it is in that of, say, UFOs. We need to remember that one of the reasons for the founding of our Society and its journal was the discordance between an identified thirst among astronomers for reliable knowledge about UFOs and the difficulty — we might say the near impossibility — of finding it. Our Society and this journal aim at remedying this deficiency in whatever fields of science it occurs. Second, apart from serving our own community of scientists concerned with research on anomalies, a recognized purpose of our Society is the further education of the general public so that its members may discriminate better between what is valuable and what is not. When we remember that Betty Eadie’s book became a best-seller, we can form some idea of how much work lies ahead. Third, we need to remember that accurate information about unexpected medical phenomena needs to be communicated to other scientists, including physicians. They should know that authentic instances of such phenomena occur, even if they are rare. When they know this, they may sharpen their observations and some may even engage in experiments like that of Rehder. We can, however, only expect to stimulate interest in this subject among other scientists by careful medical documentation and re-

porting of such cases as come to our attention. If paranormal phenomena occur in medicine — as I myself believe — I can only convince more of my colleagues to believe this by meticulous attention to the kinds of evidence scientists have a right to expect.

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