N. McLAREN MBBS FRANZCP **CONSULTANT PSYCHIATRIST**

[redacted]

February 14th 2020.

Director
Medical Board of Australia
GPO Box 9958
Brisbane QLD 4001

Dear Sir/Madam

Re: Public consultation: Draft revised *Registration standard: Continuing professional development*

Further to the invitation for public comment on proposed changes to Continuing Professional Development (CPD) programs for Australian specialist medical colleges, my submission follows. As a long-standing member of the Royal Australian and New Zealand College of Psychiatrists (RANZCP), I can only comment on my field of psychiatry.

I believe I have the qualifications and experience to speak on these matters. My observations and suggestions are based on nearly forty-six years in psychiatry in highly diverse and, very often, singularly demanding circumstances. I have a breadth and depth of experience in psychiatry which very few psychiatrists in this country could match. In addition, I regularly publish in the field of the application of the philosophy of science to psychiatry, one of a handful of people in the world to do so. Nobody has ever shown an error in any of my published work.

While my observations may be seen by some as highly critical, I rely on my status as an expert in addressing this matter of grave public importance. Moreover, it is the duty and unassailable right of any person working in a field of science to criticise the status quo, regardless of the reaction. While the whole of my income derives from my professional qualifications and experience, I stand to gain nothing from this submission.
If further information is required, please contact me at the above address.

Yours faithfully

[redacted]

N McLaren

N. McLAREN MBBS FRANZCP **CONSULTANT PSYCHIATRIST**

[redacted]

February 14th 2020.

SUBMISSION TO AHPRA REVIEW OF PSYCHIATRY CPD PROGRAM.

1. The RANZCP now has full control of training, examination, registration and continuing education of all Australian psychiatrists. In order to practice as a psychiatrist, a medical practitioner must be a member of RANZCP. In essence, the specialty of psychiatry in Australia and the RANZCP are one and the same thing.

2. The recent national Royal Commissions, covering child sexual abuse and the banking and finance industries, have shown that institutions which were once regarded as entirely trustworthy, if not beyond criticism, were both seriously corrupted and institutionally incapable of monitoring or correcting themselves. We also have the spectacle of the Victorian Royal Commission into police informers, which seems to show elements of the police force and legal profession out of control. It would be fair to say that citizens can no longer trust any institution in this country to supervise itself. There is no reason whatsover to believe that medicine in general, and psychiatry in particular, are immune to the temptations which have brought churches, banks, lawyers and police into disrepute.

The index of suspicion has permanently shifted: emollient reassurances are no longer enough. We see this in two other enquiries, the Australian Productivity Commission (APC) Enquiry into Mental Health, and the Victorian Royal Commission into Mental Health. These have drawn hundreds of submissions bitterly critical of the institution of psychiatry. In my submission to the APC (2019; No. 044; verbal submission Brisbane Dec 4th 2019), I presented figures to show that the standard response of mainstream psychiatry to any criticism, more money and more power to psychiatrists, is utterly and irredeemably wrong, that the problems lie in the institution of modern psychiatry itself and will not willingly be corrected from within.

3. Current indications are that, just by virtue of its inability to grasp the concept that it may not, in fact, be perfect, the profession is incapable of correcting itself (UN HRC 2019; McLaren 2020). I have shown a number of instances in which, when it suited its purposes, the RANZCP has simply lied to the general public and to the membership. In this respect, responsibility rests with the President and Board of the RANZCP who alone have control over public statements. For example, I remind the Board of the incident beginning in March 2018 when the RANZCP issued a press statement which, among a number of highly misleading claims, contained a wholly false statement, to wit:

> 6. The prescription of antidepressant or antipsychotic medications is something that a psychiatrist *only ever* does in partnership with the patient and after due consideration of the risks and benefits (emphasis added).

I immediately lodged a complaint with the President that she had knowingly authorised a false statement, one which met the standard definition of a lie. In short order, this complaint was rejected but, in the process, she reiterated the falsehood. I lodged a further complaint, which was also rejected. I then complained to the Australian Health Practitioners' Registration Authority (AHPRA), which twice rejected the complaint on spurious legalistic grounds (their ref: 00392770.pr). Further complaints to organisations called the National Health Practitioner Ombudsman and Privacy Commissioner and the Australian Charities and Not-for-profits Commission were also dismissed.
It now appears that the President and Board of the RANZCP can freely lie to the general public on a matter of grave importance, yet nobody in a position of authority cares. I have numerous other examples which will show that this is not an isolated incident but is part of a self-perpetuating theme of lack of professional integrity at the highest levels of the organisation and would be pleased to be able to put them before the review committee.
The point is that if the rules governing the conduct of specialist colleges are so lax that they cannot prevent officials lying to the general public, then the rules are a sham. Moreover, as the sexual abuse and banking Royal Commissions showed in brutal detail, there is no reason whatsover to expect the bodies involved to correct themselves. In the case of the medical profession, this is due, at least in part, to regulatory capture by the medical profession of the agencies which are supposed to be governing them.

4. It is just over fifty years since I first set foot on a psychiatric ward, fifty years immersed in a narrow profession. In that time, I have seen and heard everything that academic psychiatry has to say. Despite anything the profession may claim, psychiatry is in real trouble. Merely by the passage of time, all its promises over the past half-century, all its claims to be on the "cusp" of "real break-throughs" in the understanding and treatment of mental disorder, have been shown to be base, self-serving and, very often, deceitful propaganda. Regardless of anything that its boosters may say, psychiatry is not a science, it is an ideology (McLaren 2013). It does not have a model of mental disorder, or a model of mind, or of personality or of personality disorder. Its "treatments" are nothing more than crude examples of serendipity dressed in pseudo-scientific jargon, all too often written by drug companies, which is designed to obfuscate and mislead rather than to enlighten. Driven largely by the boundless torrents of money flowing from drug companies, psychiatry is riven to the core with conflicts of interests (see APC submission 2019, No. 513 for a small local example). But the most important point is that the institution of psychiatry around the world goes to very great lengths to suppress all mention of this. Even the Royal College of Psychiatrists (RCPsych) was recently caught attempting to mislead the general public on the question of whether antidepressants are addictive (Read et al 2018). Most emphatically, antidepressants reach all defined criteria for addiction; this may explain why so few psychiatrists take them (For detailed accounts of the "guild" functions of the American Psychiatric Association (APA), see Whitaker and Cosgrove 2015; on the venality of the psychiatric drug industry, see Gotzsche 2013).

5. Psychiatry shows a classic conflict between what is good for the patients and what is good for the practitioners. To a very large extent, this is, to lapse into the vernacular, a "no-brainer": inevitably, the profession wins. This is best exemplified by the RANZCP's position on electroconvulsive treatment (ECT). It is the case that the RANZCP has made a large number of claims on behalf of ECT, many of which are to be found in its Position Statement on ECT (RANZCP 2014, PS No. 74). ECT is variously said to be "valuable... irreplaceable... essential... safe... effective... necessary when indicated..." etc. In particular, it is said to be life-saving in the case of severe, intractable depression. In my review (McLaren 2018), using readily available figures, I showed that each and every one of these claims was

false. Indubitably, ECT is not safe, effective, reliable, essential, irreplaceable, necessary or anything: the only thing it achieves is to take money from the group in the community with the lowest risk of suicide (distressed, middle-aged, middle class, English-speaking women) and transfer it, at no risk, to private psychiatrists and private hospitals.
This is a matter of critical importance. When I first made these figures known in late 2016, the RANZCP attempted to silence me by a particularly underhand method. Since my review was published in the peer-reviewed literature, they have been conspicuously silent on the matter. The current rebate for ECT (Medicare Item 14224) is $71.50. I have since learned that the standard charge for ECT at a known private psychiatric hospital in Brisbane is $620 per episode. This includes the anaesthetic fee and the hospital's theatre fee, so the psychiatrist could expect one third of that sum - for about two minutes' "work." There is no conceivable clinical reason for the 87% increase in rebatable ECT in Australia between 2005-15 (including an implausible 191% increase in West Australia). I assert that the fact of the fees alone accounts for the increase.

In his short monograph, *War is a Racket,* US Maj. Gen. Smedley Butler defined a racket as:

> ...something that is not what it seems to the majority of the people. Only a small “inside” group knows what it is about. It is conducted for the benefit of the very few, at the expense of the very many. Out of (rackets), a few people make huge fortunes (Butler, 1937).

My view is that the use of ECT in this country meets that definition. Full figures are given in my 2018 review. I urge the Board not to take my claims as established, but to study that paper as it refutes everything the RANZCP has ever said about ECT. One thing is certain: the people who are making such enormous sums of money from a non-essential procedure are not going to be the first to question its value. From their point of view, albeit for non-medical reasons, ECT is indeed "valuable... irreplaceable... essential... " They have every incentive to make sure it stays that way and to suppress all criticism and questioning.

6. In this brief submission, it is not possible to look at the dishonesty of the psychiatric research and publishing industries. That information is readily available elsewhere; all that remains is for psychiatists to do their duty as science-based practitioners and submit themselves to the task of taking a critical view of their profession. In an interview on their long-term study on the damaging effects of antidepressants, Michael Hengartner, the lead author said:

> …due to institutional corruption within academic psychiatry, it is quite difficult to successfully pass the review process with (critical) papers. Most psychiatric experts reviewing for the leading scientific journals refuse peremptorily any report calling into question the merits of psychiatric drugs (MIA Editors 2019)

Psychiatrists do not read journals in order to challenge their views. They quickly scan journals in order to find material supportive of their positions. For example, psychiatrists who use ECT *never* read anything remotely critical of their practice, but mainstream editors wouldn't publish it anyway. Had the editor of *Australian and New Zealand Journal of Psychiatry* published my ECT review, he would have lost his job. There was no chance of that: self-criticism simply does not happen. The most important point about psychiatric publishing is that academics must publish to get ahead. What they publish doesn't matter because:

> (i) psychiatrists are not trained to think critically,

(ii) the material is actively filtered to remove anything remotely critical, and
(iii) nobody takes any notice of it anyway.

7. The current and proposed CPD programs are incapable of detecting and correcting major errors in psychiatry. Details from some of the author's recent cases will demonstrate this.

7 (i) In July 2017, a 2nd Year law student in Darwin hanged herself [27]. She had been managed by junior staff from Mental Health Services but it emerged that the psychiatrist who had been ordering changes in her drugs had never seen her nor spoken to any member of her family. There was absolutely nothing in her file that would amount to a psychiatric assessment. The records indicate that she died of complications of her drug treatment, not despite it. This was a complete breach of stated RANZCP policy but the college and the medical board have done nothing about it.

7 (ii) At the age of 30yrs, Ms AT was referred to a psychiatrist. Over the next ten years, she received some 438 ECT. At no stage in some 2000 pages of the psychiatrist's records is there anything approximating a proper assessment. She has no idea how much all this cost but she now has no money left to pay for the report on her management which she needs in order to initiate a complaint.

7 (iii) Mr DG spent perhaps twenty of his 43yrs in mental hospitals at a cost to the community of at least $10million. In 2014, he was tied to his bed for about 120 days while he was given some 103 ECT in succession. His records showed that at no stage had anybody taken a proper history. It emerged that the first eight years of his files had been lost (they were apparently in archives but nobody knew where, and nobody had ever looked for them). None of the approximately 450 psychiatrists and registrars who had been involved in his management over the years knew anything about his original presentation, which was actually a drug-induced psychosis.

7 (iv) Mr DO was referred to a psychiatrist for assessment for departmental purposes. The psychiatrist submitted his account but not the report. For three months, the medical officer involved rang his office to get a report, then she sent the patient elsewhere, incurring further costs. Some time later, she received a handwritten letter of about fifty words from the first psychiatrist.
The same psychiatrist saw another member of that department, who later said of the interview: "After about twenty minutes, he put his pen away, looked at me with a big grin and said, 'Well, you might as well go and kill yourself.' Then he told me to go. I don't know whether he thought he was being funny but it was the worst day of my life."
A third patient said of the same psychiatrist: "He let me talk for about 20 minutes, then he stood up and took a photo of me and said 'That's it, you can go.' He didn't ask any of the questions you've asked and just made a few notes."

7 (v) Mr MR, aged 72yrs, was referred to a psychiatrist after he suffered a head injury. The initial assessment, which led to him losing all his civil rights, consisted of 79 scribbled and largely illegible words, i.e. less than three times the length of this sentence.

7 (vi) Ms EP, a 66yo retired nurse, came from a well-known and financially secure family. Starting at the age of seventeen, she saw one psychiatrist each week for about 30yrs until he died,

then another, also weekly, until he retired. At this point, she was referred for reassessment. She had always been an anxious person but this had never been treated. She spent her entire inheritance, which would now be about $1million, on seeing psychiatrists and now lives on the old age pension. At some stage in the mid-70s, she was given unmodified ECT in the psychiatrist's office. Questioned about this, as it had long been superseded, she was adamant. Her description, was very clearly of that procedure, especially as she had many standard ECT before and after, and remembered that incident as especially terrifying.

7 (vii). 21yo student recently discharged from their twentieth admission to a private hospital after receiving 21 episodes of transcranial magnetic stimulation (TCMS). This led to increasing anxiety so the patient was admitted and given 12 ECT. The discharge summary showed two diagnoses, borderline personality disorder and bipolar affective disorder, with the following discharge medication:

fluvoxamine 300mg/day
mirtazepine 45mg nocte
topiramate 50mg bd
quetiapine 400mg nocte
aripiprazole 10mg mane
valproate 1000mg nocte
lithium 1250mg/day
lamotrigine 100mg bd
olanzapine up to 20mg/day prn
diazepam to 20mg/day
quetiapine to 600mg/day prn.

Major side effect: massive obesity.

7 (viii) 19yo patient on DSP for mental disorder, recently discharged from perhaps the fifteenth admission to private hospital in four years, longest being nearly six months. Had been put on involuntary treatment order after declining ECT. Was given about fifty ECT and was then discharged to have weekly ECT as out-patient (patient lived about 150km away). Same diagnoses as above, i.e. borderline personality disorder and bipolar affective disorder. Discharged on the following drugs:

aripiprazole 15mg mane
lamotrigine 100mg bd
lithium carbonate 500mg bd
clomipramine 300mg per day.
olanzapine 5-10mg prn, irregular dosage
quetiapine 450mg per day plus prn
diazepam 10-20mg per day

Major side effect: massive obesity.

7 (ix). At age sixteen, Mr FG came to Australia with his mother after she married a man he had never seen. He was an only child, came from a totally different climate and culture, did not speak a word of English, knew only his mother here and very emphatically did not want to leave his isolated home town where he had numerous cousins and friends from school. He quickly became depressed and was treated by MHS with large doses of many drugs and later several courses of ECT. His condition deteriorated, he began drinking heavily and using amphetamines and marijuana and became increasingly hostile to his mother and the hospital. As a result, and despite

the clear history of substance abuse, the diagnosis was revised to paranoid schizophrenia. Years later, he revealed that, just prior to leaving his homeland, a relative had told him that his father, who died when he was aged six, had committed suicide. Over eighteen years of contact with MHS, including numerous admissions and huge doses of drugs, this had never been mentioned in his 1800 pages of hospital files. As his drugs have been reduced, the faint evidence for a paranoid state has disappeared.

Patients 7 (viii), 7 (ix) and 7 (x) are slowly being withdrawn from their drugs as out-patients. In each case, the mental state is improving as the total dosage of drugs is reduced. Each of these cases had gained massive amounts of weight while taking the psychiatric drugs, which they were told was due to lack of self-discipline. Case 7 (ix) had developed quite severe abdominal symptoms which were invariably dismissed as psychosomatic. A routine history and the very briefest abdominal examination showed a colon loaded with faeces, i.e. atonic colon, secondary to the 300mg of clomipramine. This was relieved by enema, yielding a massive amount of mixed dessicated and foul liquid faeces, to the enormous gratitude of the patient. Following cessation of the clomipramine, bowel function has returned to approximately normal.

This raises a critically important point. Any non-psychiatrist looking at the lists of drugs given above would be somewhat mystified, but would assume that the prescribing psychiatrists knew what they were doing. It would be assumed that psychotropic drugs are similar to those used in the rest of medicine, i.e. they are specific for a narrow range of symptoms, and are safe, effective and reliable with minimal side effects. For psychiatric drugs, nothing could be further from the truth. The major classes are broad-acting and almost entirely non-specific, psychoactive chemicals whose mode of action on the psyche is completely unknown. All talk of neurotransmitters etc. is pure marketing. They are highly addictive drugs with a frightening range of dangerous (e.g. akathisia, obesity) and/or debilitating (e.g. loss of libido) side effects which can become permanent, if anybody can survive the withdrawal effects to find out. The drugs are not in any sense of the word "curative." It is common for patients taking these drugs, especially at the immoderate rates listed above, to double their weight. Under the influence of huge doses of olanzapine and quetiapine, one young man went from 64kg to 167kg, thereby losing nearly 5cm in height. In each case, the psychiatrists involved dismissed the weight gain as a matter of no consequence, such as lack of self-discipline.

It must not be forgotten that as the rate of prescription of psychiatric drugs climbs exponentially, the secular markers of mental disorder climb in parallel a few years later. 12% of the Australian adult population now take antidepressants, yet the national suicide rate has recently hit a peak. Similarly, there is no evidence to suggest that the ever-increasing rates of prescription of stimulants in children is producing any tangible improvement in outcomes. This is the type of "treatment" that leads people who take psychotropic drugs in the long term to die, on average, 19 years younger than their undrugged peers. It should be noted that this is a drug effect and is independent of the diagnosis (WHO 2015).

The point of these vignettes is that, in each case, the psychiatrists involved actively participated in the current CPD programs. Each of them is regarded, if not as a pillar of the local psychiatric establishment, then certainly as a valued and esteemed member, while several of them hold senior academic or administrative posts. There is nothing in the current or proposed CPD programs that can detect and/or correct this type of practice. From long experience, I can say that any other psychiatrist hearing even the slightest hint of criticism of the conduct of this type of case leaps to vehement defence of the previous treating psychiatrists.

8. The RANZCP Code of Ethics forbids psychiatrists from "exploiting" patients. Quite reasonably, exploitation is not defined, as it should be given the broadest possible interpretation. However, it is routinely ignored:

> 8 (i) Psychiatrist A in a provincial city charges $735 for an initial consultation (i.e. about 325% of the MBS fee) and continuing treatment at $450 per hour (300%). However, the reception staff inform callers that the rebate for the initial assessment is $385, which cannot be true if there is continuing treatment. Patients will be left with an out-of-pocket fee of $510 for an hour's consultation. The receptionists do not mention the rebate for follow-up appointments.
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> 8 (ii) Psychiatrist B in another city charges $720 for Item 296 and $450-550 for follow-up appointments.
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> 8 (iii) Psychiatrist C books each follow-up appointment for fifty minutes, charging $480.00. The rebate for Item 306 (45-75mins review consultation) is about $155.00, so patients are $325 out of pocket. He cheerfully boasts he sees ten patients a day for 40 weeks a year, meaning an income approaching $1million a year. There is nothing on his CV to indicate he has the psychotherapeutic training that this approach would seem to demand.

However, the most telling point is that, in return for these improper sums of money, their patients will get only the most superficial assessment followed by ever-changing presciptions (e.g. see Cases 7 (viii) and (ix) above). The psychiatrists charging these outrageous fees simply don't know enough to justify the expense, they aren't good enough at their job, which the cases outlined in Pt 7 above confirm.
The avarice of the psychiatric profession reaches its nadir in forensic cases, where the only limit is the psychiatrist's audacity. Psychiatrists preparing compulsory court reports can charge more or less what they like, so $550-600 per hr + GST is the norm. This is about 400% of the Medicare rebate for treatment, in which psychiatrists are required to practice to the highest standard. It is not the case that psychiatrists writing private forensic reports have any extra skills, or bring to the task unusual dililgence or novel insights. It is just that they know they can get away with it. I understand that, in Sydney at least (and I doubt the other capitals are far behind), the standard fee for a family report is $13,000. Having been obliged to review many forensic reports over the years, I have never seen one that showed anything like the level of expertise that could possibly justify these breath-taking fees. In short, these reports are yet another racket which psychiatrists have discovered, in which they can rely on their equally venal friends in high places to shield them from criticism. They amount to a prima facie case of exploitation but there is no prospect whatsoever that the institution of psychiatry will ever intervene to protect patients.

9. We can conclude that the current model of CPD is completely inadequate to the task of detecting or correcting inappropriate or failures of management of psychiatric disorders, either at the individual or at professional levels. My case, however, goes further, in that the CPD programs are actually designed to conceal these types of malfunctions. The programs give the impression that psychiatrists are actively participating in an educational process but it has the form only, and lacks significant content. Psychiatric journals are a model of pseudoscience, in that there is not a single journal in the world today that addresses an articulated and publicly available model of mental disorder. Anybody who does not understand the significance of this fact is not fit to be in a position of influence over psychiatry and mental health.

Overwhelmingly, psychiatrists do not understand it. Instead, they believe that whatever they believe at the moment is gospel, and critics are necessarily of malign intent (McLaren 2020). In his book, *The Trouble with Medical Journals* (2006), Richard Smith, former editor of the *British Medical Journal*, argued that medical journals have become little more than tools of the pharmaceutical industry, full of cherry-picked, misleading and ghost-written articles. *A fortiori*, his observations apply to psychiatric journals, as Hengartner and his group have shown in great and frightening detail.

Psychiatric conferences are ineffably boring, starting with the usual "keynote addresses" by "key opinion leaders" which simply reiterate the same jingoistic, "what a wonderful future psychiatry has" material that we have been hearing for half a century. This doesn't seem to trouble the speakers. A lecture by Nancy Andreassen, former editor of the *American Journal of Psychiatry* and recipient of the Congressional Medal of Honor, in Perth in 1990, was pitched at the level of a *Scientific American* article. A talk by the then president of the RCPsych, Prof. Sir Simon Wesseley, on military psychiatry (Hong Kong, May 2016), was little more than a ginger session where he amused his audience by running down his opponents on a topic which, to my knowledge, had been settled in about 2005. He did not say anything new or interesting but his audience lapped him up.

Nobody goes to psychiatric conferences to change his or her mind. At best, it is a pleasant time to catch up with old friends, enjoy some good meals at the taxpayer's expense in luxurious surroundings, and perhaps pick up a few pointers to make one feel better about whatever one is doing. For anybody with a commitment to criticism of the status quo (such psychiatrists do exist), psychiatric conferences are unendurable.

The remaining activities, at branch level, are of a similar nature. In my nearly twenty-five years in the north of this country, there were no branch activities (even though I paid for them in my annual fees). When I moved to Brisbane in 2012, I was surprised to find there was no philosophy group. In February 2013, a group met for the first time, and I presented some of my work on the application of the philosophy of science to psychiatry, albeit to a rather frosty reception. In July 2017, I lodged a submission with the Human Rights and Equal Opportunity Commission (HREOC) regarding their enquiry into the implementation of the *Optional Protocol to the Convention Against Torture* (McLaren 2017). I showed that, using the definitions provided in the *Convention* and by HREOC, most detained psychiatric patients in this country were held in breach of the *Convention Against Torture*. I circulated this to what had been renamed as the local group of the RANZCP Section on History, Philosophy and Ethics of Psychiatry, of which I was a foundation member and on whose national committee I had served until a few weeks beforehand. As a result, I was promptly excluded from the section and a complaint was lodged with the Medical Board to the effect that I was practising outside my specialty. Quite correctly, the complaint was dismissed as baseless but it consumed a great deal of my time - and my insurer's money. The Qld Branch of RANZCP has resolutely refused to provide any explanation of why I was excluded from the philosophy group. What this says is: By all means, talk as much as you like about anything you like in psychiatry, but don't say anything critical or there will be repercussions.

SUMMARY AND CONCLUSION:

The following points have been made:

1. Modern, orthodox psychiatry has no basis in science.
2. The overwhelming majority of psychiatrists do not know this but are wedded to an ideology of psychiatry.
3. Standard methods of treatment provide psychiatrists with quite outrageous incomes with little intellectual effort at no risk.
4. As the nation spends more on psychiatry, outcomes deteriorate.

5. By its control of the dominant narrative, the institution of psychiatry actively suppresses any and all criticism.
6. The current and proposed CPD regimes are incapable of detecting inappropriate or incorrect treatment.
7. No amount of tinkering with the current ideology of mental disorder or its practice will ever change anything. The forces resisting change are too great.

This very brief survey of the state of continuing education in psychiatry can only outline the major, systemic problems with the current model of CPD. These suit the psychiatric establishment as they inhibit criticism and reinforce the dominant narrative that psychiatry is a valid medical specialty with a formal basis in science, working selflessly to improve the lot of the mentally-afflicted. This is simply not true. It doesn't matter how much the Board tinkers with the present model, it will never achieve its goal of educating psychiatrists. But, of course, this sits very comfortably with the psychiatric establishment who will never debate these sorts of matters in public. Perhaps only a Royal Commission can overcome this resistance:

> It's difficult to get a man to understand something when his salary depends on his not understanding it (Upton Sinclair).

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