

Newsletter no 11: Spring 1993

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Editorial

Michael Allen deplores the "irrational nature" of the response to drug use in the UK

The editor thought he would find some illumination of his difficulties in understanding the irrational nature of the response to drug use by attending a conference on conspiracy theories. He did not.

The meeting on 9-10 January at Wembley Arena was concerned with global deception in the areas of politics, UFOs and AIDS. The speaker on AIDS presented "slides" comprising unreadable photographs of the front covers of about 30 articles presumably (they could not be read and could have referred to anything) agreeing with his stated conviction that AIDS was a man-made disease.

This not-impossible contention was turned into a conspiracy theory in which release of the virus by the CIA was postulated. A quicker death-dealing device than a slow virus taking up to 15 years to kill those affected could easily be imagined, so it was impossible to take the subject more seriously.

Certainly, nothing said could erase the opening opinion of fellow committee member Andrew Herxheimer that "with AIDS, the cock-up theory fits the facts rather better than any conspiracy theory". The major issue, that research funds may be allocated too much in accordance with conventional theory because of the nature of the peer review process could certainly not be addressed by people who take such wild swings at logic.

However, some blows have recently been struck for logic in the healthcare field:

On page 3, we are pleased to publish an article by Andrew Herxheimer describing the aims of the newly created Cochrane Centre, set up to review the results of trials of conventional therapy. Both Andrew Herxheimer and Iain Chalmers, first Director of the Cochrane Centre, are members of the HealthWatch committee. We aim to keep members informed about the work of the centre through this Newsletter.

On page 7, we report on an initiative of the American National Institutes of Health to analyse the benefits that may come from so-called "alternative" therapies.

Finally, a word of praise for the recent Public Eye programme, "Trick or Treatment", presented by Janet Trewin. Her sombre analysis of the deaths of two patients from serious diseases, which might have responded to conventional therapy, but who relied instead upon alternative therapy and diagnostic techniques, may show the beginnings of a change in the perception of these approaches by the media.

Michael Allen

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News watch

Diet doctors sell slimming

In a programme in October, "World in Action" portrayed what they called the "seedy side of medicine in Britain" when it investigated the practices of a number of doctors selling "slimming".

A team of five investigators, two slightly overweight, two normal and one 1 stone underweight, visited 50 clinics. All these visits resulted in appetite suppressant drugs being prescribed, and 45 were for amphetamines. These are apparently known as "Fergie pills" after the Duchess of York, who lost weight by unpublished as distinct from

publicised methods.

The *British National Formulary* was quoted as describing them as being "of no value to slimmers because they do not work in the long-term any benefits are outweighed by the risks". These last include headache, insomnia, hypertension, rashes and depression. One diet doctor said that the pills increase IQ and help the absorption of information, as well as improving job performance and driving skills. One in five of the clinics visited did not even take the name of the client's GP, and none made contact with the GP.

Twenty-one did not measure height but took the client's word; 25% failed to check blood pressure and one did not even have a stethoscope for this purpose. *Three clinics did not weigh* the client, and a Harley Street clinic that offered "medically controlled weight loss" *did not even possess scales*.

The team included a girl who was 1 stone underweight. Five of the clinics that she visited gave her appetite depressant pills. In one she was weighed with her coat, shoes and handbag, presumably to add some weight. She was given a diet of 800-900 Calories and a supply of pills. She was told that she might want to go down to 600-700 Calories a day, depending on how slim she wanted to be (she posed as a model).

Official view

These reprehensible practices were roundly condemned by several medical specialists who appeared on the programme, including the Chairman of the DoH Committee on Toxicology, who described the practices as beyond belief and the pills as poison.

It is not likely that potential victims would see this programme nor believe it if told, since they usually hope for an easy way to lose weight, such as by a magic pill. One victim said that she went to a diet doctor in total desperation and others interviewed said that they had become hooked on the drugs.

Amphetamines can suppress growth and are therefore contra-indicated for children, yet ten clinics were willing to see a 15-year-old patient. She was an actress who was given both capsules and tablets which one doctor said were perfectly safe and "do not affect your mood or anything.. He agreed that they should not be given to children but said that the patient was fully grown and that he helped her because she was clearly overweight and had travelled a long way. Another said that children over the age of 12 could take the pills.

One diet doctor travelled from one rented hall to another and sold Fergie pills from 65 clinics, with more opening (he attended six in one afternoon). He tells his customers to send their friends, especially if they have a lot of money.

Anyone can open a clinic, so long as they have a doctor on board, but in three instances there was *no doctor present* nor was the patient seen by a doctor at any time, and an unqualified person sold prescription-only drugs, clearly an illegal act.

The programme reported the death of one woman due to "heart attack and amphetamine use". Apparently, the drug exaggerated a heart condition that the doctor did not know about.

It will be instructive to see whether authority can take any action. HealthWatch commends this excellent piece of investigative reporting.

[Arnold Bender](#)

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Journal of Nutritional Medicine calls for register of controlled trials of nutritional interventions

Claims and counterclaims about the effects of nutritional interventions seem likely to remain a feature of the interface between orthodox and complementary medicine.

Because controlled trials have demonstrated the potential for some dietary interventions to protect and promote health, it is obviously important to identify other health-promoting nutritional interventions efficiently.

As Dr Damien Downing points out in a recent editorial in the *Journal of Nutritional Medicine* (1), some aspects of current debates about the effects of manipulating diet could be addressed by doing more systematic reviews of the results of existing controlled trials. He points out that informative reviews depend first, on investigators doing well-designed primary studies and making sure that *all* well designed trials are properly reported, and second, on reviewers applying a more systematic and scientific approach to the review process itself.

A starting place for systematic reviews would be a comprehensive register of nutritional intervention studies. Dr Downing calls for such a register to be established, and pledges the support of the Editors of the *Journal of Nutritional Medicine* to assist in this as far as it is in their powers to do so. All offers of help or funding should be addressed to: The Treasurer, British Society for Nutritional Medicine, POJ Box 3AP, London W1A J3AP.

The Cochrane Centre: born on 1 October 1992

The Cochrane Centre is part of the recently launched Research and Development Programme of the National Health Service. Its task is to facilitate and extend the creation of systematic reviews of randomised controlled trials (RCTs) evaluating health care. It is named after Archie Cochrane (1909-1988), a great epidemiologist, who was the first to emphasise that reliable information from RCTs, together with other essential information, is vital for making sound decisions in health care and research.

With collaborators in Britain and elsewhere, the Cochrane Centre will help to assemble and disseminate evidence derived from systematic reviews of RCTs. Specifically, it will work with others in building and maintaining a database of systematic, up-to-date reviews of RCTs of health care, and to make them readily accessible through electronic media. The Centre gives priority to collaboration with people who are already updating existing systematic reviews of RCTs, and will incorporate structured summaries of their reviews in its database.

The Centre is linked with the Clinical Trial Service Unit at Oxford University, the Department of Clinical Epidemiology and Biostatistics at McMaster University, and the new On-Line Journal of Current Clinical Trials published by the American Association for the Advancement of Science.

How the Centre will help reviewers

The time needed to prepare valid reviews of RCTs tends to be grossly underestimated. Lack of experience and time often force good scientists to produce scientifically inadequate reviews. The Centre will give practical support to those preparing and updating reviews.

Systematic reviews of RCTs must be based on as high a proportion of eligible studies as possible. In addition to the Centre's library of published reviews of RCTs, therefore, the Centre is helping to assemble as comprehensive as possible a register of RCTs. Because the use of bibliographic databases like Medline identifies only around 50% of RCTs, selected journals will be searched by hand. Efforts are meanwhile being made to improve the rate of RCT retrieval from bibliographic databases in future. The register of RCTs will also aim to include references to unpublished, ongoing and planned controlled trials, so that people preparing systematic reviews can consider them. The register of reviews of RCTs of health care will likewise include details of systematic reviews which are being prepared or planned. These resources will help those working with the Centre, and will help to identify others who wish to prepare, update and amend additional systematic reviews of RCTs for inclusion in the Centre's database.

The Centre will organise seminars and workshops for people preparing reviews of RCTs, and develop protocols and software to help them with the review process. With its collaborators, it will develop policies and set standards for systematic reviews of RCTs. It will also work with people doing relevant methodological research.

An editorial system based on review groups

The Centre will encourage those contributing reviews to form collaborative review groups, each coordinated by a core editorial team which oversees a group of related reviews. These groups may be problem based (e.g. breast cancer), intervention-based (e.g. nutrition) or specialty-based (e.g. primary care). Reviewers considering whether to form a collaborative review group can attend workshops to discuss some of the likely implications with already established groups. That responsible for reviewing RCTs in pregnancy and childbirth now maintains over 500 systematic reviews of RCTs, prepared by over 30 reviewers in seven countries; it has to deal with 200-300 new reports of trials every year. The core editorial team consists of four editors, an administrator and a data clerk.

The module of reviews of RCTs in pregnancy and childbirth is being used as the pilot to explore how best to develop a module-based system for building, updating and disseminating the Centre's core database. It is essential, for example, to make it easy for the reviews to be criticised and amended when necessary. The use of electronic publications, such as the *Online Journal of current clinical Trials*, should greatly facilitate interaction between critics, authors and editors of the reviews.

Because the Centre's database will be updated and amended constantly, electronic media offer obvious advantages for disseminating its contents. The complete core database will be distributed on-line and on CD-ROM; smaller, specialised databases will be compiled for publication on floppy disk.

Andrew Herxheimer, Consultant, Cochrane Centre

Independent Television has a regular programme called "The Time and the Place". The time is 10 a.m., so who watches it? Presumably not the young and not the working population. The place is London, although the programme is seen all over the UK.

The main idea on this occasion was to discuss alternative medicine and miracle healing for 40 minutes so the studio was full of starry eyed healers and healed, plus one or two (in marked contrast) who felt they had been ripped off by quacks. The final ingredient that the producer needed was the statutory orthodox doctor to be a sort of wet blanket after each miracle cure had been described. HealthWatch was asked to supply such a person, and this time it was my turn.

Where would the programme have turned to if there had been no HealthWatch? The BMA? We shall never know. It was HealthWatch, and I had to do my best with the four or five occasions when the presenter wheeled round to me with, "How about that, Doc? Seems a pretty amazing result, you must admit?" And any comment had to be fairly snappy.

Viewers heard how patients had lived much longer than expected - or done much better than expected - and I pointed out that I had often seen the same thing happen after orthodox treatment; facts and figures for most medical conditions, including cancer, always showing a few patients doing not just better than average, but far better than average. If you really want to know, I suggested, how much good your treatment is doing, and whether, in various situations, it is best or only second best, you have to do a proper comparison. And if you are not to come to false conclusions, the groups you are comparing have to be as alike as possible except for the method of treatment.

Everyone agreed that it was common for people to have both orthodox and alternative medical treatment; and I commented that it was a bit hard on the doctors and nurses who had worked hard to give everyone the best possible chance, if it was the alternative medicine that got all the credit when the patient did well!

Thurstan Brewin

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Good Clinical Practice: uncommon care in the Common Market

As we progress towards the completion of the internal market in the European Community, it is apparent that newly approved pharmaceuticals are to be regarded as products entitled to free circulation and that individual Member States' "sovereignty" in decisions on the quality, safety and efficacy of medicines will not be absolute. A number of highly complex proposals are being debated at the European Parliament and within the Committee on Proprietary Medicinal Products [CPMP] of the EC which will eventually result in some form of pan-EC decision-making structure on the approval of medicines.

In advance of the changes, the CPMP has established guidelines intended to harmonise attitudes between Member States. For the physician involved in research one of the most significant is the Note for Guidance concerning Good Clinical Practice (GCP) [1]. This came into effect on July 1st 1991 as a Recommendation, adherence to the guidelines being required for all clinical trials intended for drug approval purposes in any EC Member State agreeing to conform. An EC discussion paper [2] proposes that these guidelines should be incorporated into a Directive which will eventually give them legal force in all Member States. Because trials conducted in a way that deviates from the guidelines will no longer qualify for consideration in the drug approval process, GCP can no longer be considered voluntary" in pivotal Pharmaceutical Industry sponsored trials, though remains so for trials initiated outside the approval process.

As current practices in individual Member States cover a large variety of different standards and views this harmonised standard is desirable for public protection. This article considers what effect these guidelines will have on the investigator.

What is Good Clinical Practice?

GCP is not directly concerned with the real issues of good clinical practice, such as the delivery of good clinical care to the patient. It has two primary aims: firstly to ensure the human rights of research subjects are respected; secondly to ensure the accuracy of the record and prevent fraud.

In the first of these aims, GCP guidelines introduce nothing new. Informed consent of the patient to experimental procedures and review of the protocol by an Ethics Committee are GCP requirements. However, the principles of informed consent were stated in the Nuremberg Code, then incorporated into the Helsinki Declaration by the World Medical Association. Recognition of patient autonomy and provision of Ethics Committee protection developed as purely professional initiatives; all that changes is that current best professional standards will be maintained universally and eventually become legal requirements.

The second aim is met by establishing a system for detailed documentation of all actions concerned with the trial subject's management by the research clinic. It is here that the guidelines introduce a number of things which will be new to many investigators. They will need to enter into firm contractual arrangements with the sponsoring company and arrange liability and compensation before the trial commences. They will need to control trial-

related activities by means of written Standard Operating Procedures, rather than informally.

Precise methods of documentation of all trial events must be adopted and many specific obligations fall directly upon the principal investigator, who becomes the first and key factor in the quality control process, while still keeping all the usual responsibilities for patient health.

The sponsoring pharmaceutical company has the obligation to monitor the study throughout its run and to perform an independent audit of the investigator's systems and data record. A further inspection and audit on behalf of governmental Regulatory Authorities is allowed for in the guidelines, though arrangements to do this have not yet been announced in all Member States. The investigator will be involved in these inspections, which increase the burden of work upon the clinic.

Another very onerous requirement is that the archive containing source data on patients involved in the trial must be kept by the investigator for a minimum period of 15 years, with the implicit assumption that governmental audit could be long-delayed or might be repeated. Such long storage itself presents a major practical problem for an investigator who, like most, moves from one appointment to another in the course of his or her career; source data includes the patients' notes. The recent UK Health Service Guidelines [3] on the establishment and function of Ethics Committees state that the consent of the Ethics Committee and the appropriate NHS Management body is required if personal files are to be retained after the original research is finished. This means yet more bureaucracy will be involved for the research physician.

One aim stated in the EC discussion paper [2] is that the EC should eventually harmonise GCP not only within Member States, but also with countries outside the Community. This means one must look at America, which has the best established system of GCP. American GCP regulations are codified in Title 21 of the Code of Federal Regulations [21CFR], and define [amongst other things] how human subjects are to be protected and informed consent obtained; the membership and function and operation of the Institutional Review Board [Ethics Committee]; and responsibilities of sponsors and investigators.

Sponsors, Institutional Review Boards and Investigators are subject to inspection by a large team of Federal investigators looking for defined standards [4]. The basic principles of GCP do not differ, except that in America regulations are established in Federal Law whereas, for the meantime, GCP remains a professional concern in the Community.

GCP obligations, concerned primarily with the accuracy of the record, do nothing to improve the scientific quality of the study. This seems a great deal of work for what may be a small reward. How much fraud actually occurs and will GCP prevent or detect it?

Fraud and Good Clinical Practice

Experience in America, where the full system of inspection has been in place for several years, shows that some frank fraud still occurs. Recent disclosures and prosecutions in America [reviewed in 5] show the value of GCP in the detection of fraud. Audit detected that one company, instead of comparing their new product to the other with which bioequivalence was to be claimed, used the standard product in both arms of the clinical study. Detection of such fraud is beyond what could be achieved today in Europe, but audit within a GCP system would make this possible.

It is argued that the traditional professional process of peer review works well enough to prevent fraud. One case detected by peer review is that of Professor Michael Briggs' study of the metabolic and haematologic effects of new hormone contraceptives [6]. Four years later senior scientists from Deakin and Melbourne Universities expressed their disquiet [7] and eventually the assumption was made that the data were fraudulent.

The peer review process took several years to show these results should not be relied upon, whereas application of GCP methodology would have detected the problems before publication.

It is hard to say if there is much current fraud or inaccuracy in European clinical research; many scientists have known an uncomfortable feeling about recruitment of patients in large numbers from a small catchment area, but evidence has traditionally been elusive.

With GCP guidelines in place and an absolute need for companies to comply if they wish to get approval for their new drugs, some worries about Pharmaceutical Industry sponsored research should be disabused. Because of the standardised and repetitive nature of the research in a drug development programme, it is not usual for the major studies on which drug approval is based to be published in peer-reviewed journals and this is especially true for "me-too" drugs which seem to offer no exciting benefits. The review process within the governmental Regulatory Authority approval process is at least as severe; the current UK system obtains expert committee review in addition to the internal assessment in the highly professional Medicines Control Agency. But the medical profession's view of this research is unfavourably coloured by the existence of promotional studies performed outside of the approval process, often to a lower standard; also the confidential nature of the Regulatory Authority review process does not inspire confidence in scientists used to a more open approach.

With GCP in place the peer review made within the approval process will have a sounder base. It is widely

expected that the good will drive out the bad over the next short period and allow well-founded trust to be placed in Pharmaceutical Industry sponsored research wherever it is performed in the European Community. If products are soon to be approved by one of the proposed pan-EC procedures, it is good this should be so.

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This article was written by Michael E Allen, EPharm MBIRA, treasurer of HealthWatch.

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NIH tackles "alternative" medicine

Specialists in acupuncture, homeopathy, naturopathy and holistic healing, a Harvard Medical Professor and a former congressman were among those attending the first meeting of the NIH's new Advisory Panel on Unconventional Medical Practices, established to look at "alternative" healing practices and recommend those worth using. The meeting was held in June 1992.

About 80 speakers discussed a wide spectrum of unconventional practices at the conference. Jay Moskowitz, NIH associate director for science policy and legislation, expressed optimism about the project, saying that it would "provide opportunities for an expanded research effort that will ultimately improve the health and quality of life of every man, woman and child in this country".

The definition of unconventional medical practices is broad, but NIH interprets it to mean diagnostic or therapeutic techniques that traditional practitioners consider outside the mainstream of scientific research.

Dr Moskowitz stressed that NIH has always encouraged the pursuit of novel ideas and new therapeutic approaches, and he hoped that the new venture would allow the creativity and innovative thinking of people both outside and inside the field of conventional medicine to be utilised fully, while adhering to the principles of sound scientific evaluation.

NIH will offer technical and financial resources for rigorous scientific evaluation of the claims made for some alternative medical practices, although it was admitted that some of these practices do not lend themselves to traditional scientific evaluation. It might therefore be necessary to develop new methods to establish their efficacy and safety.

The initiative is expected to draw a mixed response from US practitioners, some of whom may well regard it as encouraging quackery". However, Dr Moskowitz noted that many medical discoveries have grown out of theories that society at first ridiculed as inconsistent with the conventional thinking of the day.

The National Cancer Institute has already taken steps to evaluate unconventional therapies, and clinical trials are taking place for two therapies: hydrazine sulphate and visualisation therapy. NCI is expected to file an application for clinical trials for antineoplastic agents in the near future, and has reaffirmed its commitment to identifying novel approaches for the treatment of cancer, whatever the source.

(Taken from American Medical News, August 3, 1992)

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Complementary medicine. Still no chair to sit upon?

HealthWatch was very interested to note that the University of Exeter has created the Laing Chair in Complementary Medicine. We decided we would wish to interview the person appointed. Our request to do this last December was politely met by the Director of Personnel by the information that "it may be some weeks before an appointment is confirmed".

HealthWatch believes that, not least among important issues to be considered, is the qualification and

background of a person considered appropriate to hold a Chair in such a specialty. We will maintain contact with the University and keep our members informed about this interesting development.

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Position paper: Cancer

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Many people still think of cancer as a death sentence, but for every 300 people who get it about 100 are cured and this has been so for many years. More people get cancer now than did in the last century, but this is because far fewer die from infectious diseases in childhood or early adult life, so more live to an age when cancer becomes common. Provided a person does not smoke cigarettes, the chance of getting cancer at any particular age is less than it was 100 years ago. Cancer of the stomach, for example, occurs much less often than it used to. Nobody knows why. And when children get cancer they are now far more often cured.

There are about twenty common kinds of cancer (and many uncommon kinds) and they are unconnected. Having one kind does not seem to be associated with having another kind. They start in different parts of the body; spread differently and have different causes for example smoking makes some kinds more likely but not others). Some cancers progress quickly after diagnosis, but many so slowly that it is possible to live well for a long time, even with a tumour that is clearly still present. Just the thought of it being there may then be the main problem. And some types of cancer respond much better to treatment than do others. For example, some types of leukaemia are far more curable in children than in middle age; while chronic lymphatic leukaemia affects mainly the elderly and, helped by treatment, can sometimes go on for years without becoming serious. Finally, within each group, there are individual variations - bitter disappointments and pleasant surprises being equally common. Cure can never be promised, but in some cases the chances are good. For example, nine out of ten skin cancers are cured; and with cancer of the cervix there are more cured than not cured. And there is no kind of cancer where the proportion alive and well 5 years later is less than 5%. A figure like this sounds either hopeless or far from hopeless according to how you choose to look at it. At least it means that the chance of cure (1 in 20) is a lot better than the chance of a win on the football pools. Or take the figures for lung cancer (which we discovered how to prevent nearly 40 years ago - non-smokers hardly ever get it, smokers frequently do - but which we usually cannot cure). About 93% die within 5 years, many of them within 5 months. This sounds terrible, but on the other hand it means that each year if 30,000 die, 2000 survive. So even with a cancer as serious as this, cure is not just a rare miracle.

The second thing that is often achieved by treatment (surgery, radiotherapy or chemotherapy) is complete healing and restoration to health for many months or years, even though it may finally turn out that the person was not cured. Every radiotherapy centre, for example, has photographs and scans showing how disappearance of abnormality has been achieved without any surgery. Such gratifying results occur hundreds of times more commonly after orthodox treatment than after any unorthodox kind.

Sometimes there is no further trouble at the original site, but several years later secondary deposits appear, perhaps in the bones or the lungs or the liver. In other types of cancer there is no risk of such spread to other parts of the body; if recurrence occurs it is at the original site. If a healed cancer returns years later in this way the sequence of events is really no different from what happens when a person nearly dies from a heart attack - and is then well for years before dying from a second attack. But for some reason most people find it more depressing when it is cancer.

One reason for this different attitude may be that for the heart to fail in some way, especially in older people, seems almost natural (or at least not surprising) whereas cancer is regarded as unnatural, frightening and evil. This would be true if cell multiplication were foreign to the human body, but it is not. Throughout our lives normal cells are multiplying in order to restore and keep healthy the lining of all the various tubes and cavities in our bodies; and it is in these linings - the technical word is epithelium - that most cancers start. The way in which this constant cell production is controlled is remarkable and it would be strange if the control mechanism did not sometimes fail (perhaps several factors contributing to this).

Another reason for the special fear of cancer - compared with other equally serious diseases - is the fear that to die of cancer is the worst way to die. Sometimes it is. But many cancer patients die peacefully, either because they never have pain; because radiotherapy or other treatment successfully relieved it; or thanks to adequate doses of morphine (many people remaining alert in spite of large doses). Harder to help than pain can be discomfort or nausea, or just feeling ill and weak, but there is always something that can be done. And it is remarkable what a difference it makes if the doctor or nurse is natural and friendly, glad to see the patient, not embarrassed or awkward because the outlook is so bad, and keen to help in every possible way, physical, psychological or practical.

Prevention is always better than cure. What can be done to prevent the common cancers, apart from not smoking? Too much exposure to the sun makes skin cancer more likely. And certain diets probably lessen the chances of getting certain kinds of cancer. But the evidence is not as clear cut as it is with cigarettes. However, what is intriguing - and hopeful for the future - is that there is no form of cancer that is common in one part of the

world that is not much less common in another part. If this was due to certain races being more susceptible than others there would not be much that we could do about it. But we know that it is not that. When people emigrate to other parts of the world, the cancers they get soon become the same as for those already living there. Japanese women, for example, so long as they stay in Japan, get far less breast cancer than American or European women. But not when they go and live in America. So either there is something in the water, or the food, or the air, or whatever, in Japan that protects against breast cancer, or something in the Western way of life makes it more likely.

In recent years it has been realised that some cancer treatments have been more drastic than they need have been. Gentler treatment has sometimes produced the same results - less drastic surgery, less severe radiotherapy, or easier chemotherapy. If every new treatment had been properly compared (from the start) with existing treatments this would not have happened and we would know when drastic treatment was justified by results or when it was not. This is one of the reasons why HealthWatch urges more clinical trials - not just of orthodox treatments but also of unorthodox ones - as discussed in another of our position papers. In a formal randomised comparison between two treatments nobody is a "guinea pig"; everyone gets fully treated; and nobody has anything done to them that would not have been done if the treatment had been given without this formal comparison. Without such trials it is all too easy to come to false conclusions.

A single cure for all cancers seems unlikely. Growth disorders of this kind - or something very like it - occur in all animals and even in plants. But much can already be done and there seems little doubt that we shall soon know more about both prevention and treatment.

Thurstan Brewin

(endorsed by the Executive Committee)

See also article by Professor Michael Baum in [Newsletter no 6](#)

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