

Newsletter no 31: October 1998

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Sincerity is not enough

Some of HealthWatch's critics think it's unnecessary or impractical for all methods of diagnosis and treatment to be tested by properly designed trials. If a physician believes he has a useful therapy, and patients find his treatment helpful, is it ethical that he should be required to give some control patients an alternative treatment just to prove that his treatment works? The answer is "yes", argues Professor John Garrow.

The need for controlled trials is at present being dramatically demonstrated in Italy. Professor Luigi Di Bella claims that over the past 25 years he has successfully treated more than 90% of 10,000 cancer patients with a cocktail of drugs including melatonin and somatostatin, but he has never presented his data for critical review, so the Health Ministry would not fund this treatment.

Recently a judge ordered the local hospital to provide the treatment and, backed by massive media pressure, the Health Ministry has now been forced to set up trials on 2,600 patients at a cost of up to US\$6,000 per month per patient.

Enthusiasm for the Di Bella cancer treatment is not confined to Italy. At Easter Sky News ran a feature on it, and on May 16th the Canadian Broadcasting Corporation held a live televised press conference at which Professor Di Bella explained his treatment to an invited audience at a television studio in Hillingdon. HealthWatch accepted an invitation to attend. The studio audience sat on the right of the central gangway if they were Italian-speaking, and on the left if they were English-speaking. Professor Di Bella spoke in Italian, and an English translation was provided by a loudspeaker on the left side of the studio.

He is a handsome man aged 85 years, who is obviously sincere in his belief that he has an effective cure for all forms of cancer. For 40 minutes he reviewed the research which led him to believe that various natural substances affect growth (vitamin A, somatostatin and similar compounds, prolactin and melatonin). Since cancer is disordered growth in cells, these substances offer a possibility to inhibit growth in cancer tissue. The evidence of efficacy he presented was anecdotal: a young woman with breast cancer had a high prolactin level, which fell on his treatment (which includes bromocriptine, a well-known prolactin inhibitor). However she could not afford to keep up the treatment, so she stopped the medication, her prolactin increased, and sadly she died. It was (said the professor) "one of the clearest demonstrations" that his theories on cancer growth were correct. In general he found the results in patients "very encouraging", but said he had problems with legislators in Italy, and in getting his therapeutic preparations properly dispensed.

There followed a 15 minute question period; the questions were all in English, and were translated to Professor Di Bella. The first questioner was clearly a Di Bella devotee: he too knew the cause of cancer, and could cure it, but he hinted darkly that commercial interests prevented effective cancer cures reaching the public. Professor Di Bella was confused about how he should respond, since it was not a question, and neither he (nor the representative of HealthWatch) understood the point which was being made. In the uneasy silence which followed HealthWatch was able to ask Professor Di Bella if it was true that the Italian government would not fund his treatment, because he had never presented his results for external assessment. Clearly he was now on familiar ground. He was not interested in this type of argument. He thought physicians should have the freedom to treat patients, and choice should not be limited. Some of the objections to his treatment were not in good faith. If he could not do his work in Italy there were hospitals in Brazil where he would go.

Other questioners suggested he was exploiting vulnerable patients, by promoting unproven cures. He responded that he merely offered his treatment which they could take or not. Had any patients cancer which had advanced too far for treatment? Yes, treatment had to be "timely", it would not work if vital organs were affected. Would his treatment cure any kind of cancer? The treatment had to be "modulated" to suit different cancers, but the principle was the same for all of them. The final question returned to the first cryptic questioner, who restated his point with no greater clarity, and time had run out.

Whose fault is it that the Italian health service is now expensively defending its decision not to fund the Di Bella cancer cure? The responsibility must be shared between Professor Di Bella for not rigorously testing his ideas 25 years ago; the judge for not understanding that the efficacy of a treatment is not a matter of opinion, but of testable fact; and the media for promoting views without firm evidence, and thus abusing their power. Any country which does not want to be caught in such a mess must have a culture which understands the need for controlled clinical trials. We are sure that Professor Di Bella is sincere, but in healthcare sincerity is not sufficient.

See also [Newsletter no 34](#)

John Garrow Chairman of HealthWatch

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Di Bella trials: a post script

A committee of international cancer experts invited by the Italian Government to test Professor Di Bella's remedy recently concluded that his treatment is ineffective and may even be harmful, according to a report in the health communications newsletter *Patient i*.

Professor Gordon McVie, head of the Cancer Research Campaign and a member of the committee, said that of 136 patients on the trial 100 were now dead or their tumours had progressed. "There is no measurable response in any of the patients at all after two months of treatment," the report quotes him as saying. He is also reported to have said that the cocktail of drugs and vitamins prescribed by Professor Di Bella caused vomiting, drowsiness and diarrhoea.

Professor Di Bella, according to *Patient i*, said the trials had been rigged.

Patient i Issue 17, August 1998

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NEWS

Skrabanek Foundation offers £1,000 writing prize

As many of our readers will be aware, Petr Skrabanek died in 1994 at a relatively young age of aggressive prostate cancer. Since this time many of his friends and former colleagues have met together from time to time under the umbrella of an informal Skrabanek Foundation.

This Foundation is now legally established as a limited company with charitable status. It is now seeking to formalise its membership, details available from James McCormick, The Skrabanek Foundation, Trinity College, 199 Pearse Street, Dublin 2. E-mail mccrmckj@tcd.ie

The objectives of the Foundation are, "to provide public education both in Ireland and elsewhere on the merits of scepticism and critical appraisal in the fields of medicine and research, including the dissemination of knowledge and the results of research studies undertaken to test both generally accepted and alternative medical practices, theories and treatments."

To this end there have been two Foundation lectures, the first by Professor Michael Baum, the second by Professor Lewis Wolpert. A third is planned for next March.

The Foundation has offered a prize to the value of £1,000 sterling for the best recently published piece which furthers the objectives of the Foundation. The last winner was Dr Angela Raffle for her Lancet paper on cervical cancer screening.

Once again the prize is being offered, in this instance for something published since December 31st 1996. Submissions may be made by authors or anyone else. Three copies of the work to be considered should be sent to the Foundation by 31st December 1998.

The Foundation also hopes to publish a book of Petr's seminal papers which should be available by the end of the year.

Any suggestions for appropriate initiatives and activities would be welcome.

Polly Toynbee to receive award at HealthWatch AGM

Leading journalist Polly Toynbee is set to receive the 1998 HealthWatch award for her work in helping the public become better informed on health matters. As well as accepting the award at this year's Annual General Meeting, she has agreed to lead a 30-minute discussion session on a topic of interest to members attending the meeting. Nick Ross, Chairman of HealthWatch, will chair the meeting as usual.

The date of the AGM has been set for Wednesday 21st October. It will begin at 6pm at a new venue - the Society of Genealogists, 14 Charterhouse Buildings, London EC1 (within walking distance of Barbican tube station). The meeting is to be followed by dinner at Searcy's restaurant at the nearby Barbican Arts Centre. Members will receive a booking form with a map and details of the cost of attending the dinner.

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Ireland sees return of the NuTron Diet

A worried member has issued an appeal to immunologists or other related health professionals among HealthWatch's membership for medical information and expert advice on the NuTron Diet.

Our member, who lives in Northern Ireland, e-mailed us recently to express alarm at the re-emergence of a diet plan which was widely discredited in the English press some years ago but which is now being promoted heavily by some of the regional press in her area.

The NuTron Diet involves testing your blood in order to devise personal diet sheets for you [1]. The sheet excludes foods to which, it says, you have an intolerance. Back in 1994 Which? magazine [2] investigated the claims of the company promoting the plan, by sending in two blood samples from the same person under different names. They received two diet sheets—one listing 20 foods to avoid, the other 12—there were only five foods in common to both lists. More dangerously, the company failed to notice that the investigator was intolerant to gluten and similar proteins because of coeliac disease. It listed gluten, along with rye, wheat and oats (all of which must be avoided with this condition) as safe to eat and company representatives, when challenged, explained that the test could not be expected to pick up gluten allergy. Experts reported in Which? that the diet may lead to a loss of weight simply because it bans a lot of high-calorie foods.

According to our member, Trading Standards officers in Northern Ireland who have been alerted to the promotion of the NuTron Diet, are very interested in investigating further. They would like to know more about the medical and scientific standpoint on NuTron blood tests. "Are there," asks our member, "any HealthWatch immunologists or other medical professionals who would be prepared to offer Trading Standards their informed opinion on this subject?"

See also [Newsletter no 17](#), February 1995

References

1. HealthWatch newsletter, issue 17, February 1995.
2. Which? November 1994

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MEDIA

Keeping the faith

There was an uncomfortable moment in Esther (BBC2, 8 September, 4.55pm) when the generous and sensitive spiritual healer turned and barked in a rather nasty fashion at a young widow whose own personal tragedy had given her a somewhat sceptical viewpoint. Perhaps it was nerves.

To be fair, though, host Raj Persaud kept the programme well under control compared to studio discussion programmes we've seen which dissolve into slanging matches. Everyone had a fair say, from a pleasant chap whose healing hands apparently saved a horse's racing career, to the woman who summons healing from angels (yes, really), and the dancer whose hip is back in action after a session with the first-mentioned spiritualist (she was thrilled with the results, even though her injury hadn't been serious enough to bother her own doctor with).

The spiritualists, representing some 20,000 in the UK, were terribly careful not to claim that they ever promise cures, or that they ever excuse failures by asserting that the un-healed lacked faith. They had, they said, many examples of people with ligament problems, migraines and, of course, cancer who were now well. And many, it was admitted, who are no better—after all, they did say they didn't make promises.

A particularly eloquent GP was given a front seat and the time to put forward balancing medical opinion. Sometimes, he had to say several times, diseases do just disappear for no reason whatsoever. Cancers spontaneously regress. Lumps vanish. Couples who appear infertile occasionally conceive out of the blue. People feel less depressed after having their hand held. Even in general practice.

But can healing work to order? Early on, the personable horse healer was given the 20-odd minutes remaining of the programme to relieve the painful ankle of a disgruntled man sitting next to him. A tall order, but the healer seemed so game that I rather hoped the "treatment" would work to spite the patient's grouchiness. By the end of the programme, though, the ankle was no better, and I waited for someone to say, "but he didn't want to be healed anyway." No-one did, but I suspect a few were thinking it.

Mandy Payne

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Get on your bike, Grandpa (or cut the grass)

"When I was your age..." I tell my grandchildren, as a prelude to a sermon on how fit and active I used to be, and never watched television. I hope the Lancet of 5th September does not fall into their hands, because it would provide them with a telling response.

Norwegian researchers recruited over 2,000 healthy middle-aged (40–60y) men 22 years ago and measured their physical fitness. They found (of course) that physically fit men are less likely to die in the next 22 years from heart disease, or any other cause, than age-matched unfit men.

However the wily Norwegians add a new twist to the story: they re-measured the physical fitness of their subjects seven years after recruitment, and now can report on the effect of change in fitness on later mortality. There is a highly significant reduction in mortality among those who increased in fitness in the seven years after recruitment, compared with those who became less fit, regardless of the initial level of fitness.

The authors comment that many older people rely on drug therapies and medical interventions to improve their health, but their data suggest that moderate improvements in physical fitness, particularly among those who are least fit, bring substantial benefits to health. I think I will go and cut the grass now, but don't tell the grandchildren.

John Garrow Chairman of HealthWatch

Reference: Erikssen G *et al.* Changes in physical fitness and changes in mortality. Lancet 1998; 352: 759–62.

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INDUSTRY

Virtual Companies and CRonyism

The pharmaceutical industry is evolving. Michael Allen is concerned that in the emerging global company environment, there may be an increasing risk of decisions on clinical safety and efficacy being distorted by commercial considerations.

Those involved in research on new medicines may already have noticed a clause in their long contract with the company stating that the data are part of the intellectual property of the company and may not be published without consent. Worse, contracts may have been signed by busy researchers who did not notice this clause.

This directly contravenes the advice of the Royal College of Physicians¹ but its removal may be very difficult for any UK unit wishing to keep up to the minute with new research. Companies are well aware of the need for research units to perform research to keep their critical mass and may not take easily to a request for re-negotiation. Changes in the structure of the pharmaceutical industry suggest that maintenance of independence and freedom to publish is more important today than ever before.

The pharmaceutical industry is changing in ways typical to those occurring in many other industries. With the seeming complete world-wide triumph of free trade (so-called neo-liberalism), has come a fashion of company conglomeration. The pharmaceutical industry is moving rapidly toward the situation where only a few enormous global companies will exist; as their numbers reduce, so their names get longer. The industry also shows a modern tendency to become "virtual": this involves the retention of a small group of highly business-trained scientists and executives to manage an enormous quantity of work, which is put out to specialist companies.

This tendency has not deeply penetrated into basic chemical and biological drug research, usually retained by the companies, but is an increasing practice in the development phase. For many years it has been the practice for animal safety studies to be placed with specialist laboratories; now it is increasingly common practice to contract out also the clinical phase of the development work. Twenty years ago clinical Contract Research Organisations (CRO's) were something of a cottage industry, companies often being set up by those retiring from the industry.

A number of very large global CRO's have recently emerged through growth and acquisition. Their structures mirror those of the companies they work for, so they can take advantage of the global contracts now on offer: a sort of managerial equivalent of the first law of thermodynamics.

Meanwhile in the United Kingdom, as elsewhere, clinical research on new drugs has moved firmly into the hands of the industry. This tendency was present before the last government's changes to the NHS; these, in particular the formation of independent trusts, have completed the move. Trusts and charities do not see it as their role to perform studies which might eventually benefit a drug company by establishing the use of a new medicine. This work must be funded entirely by the company.

The performance of clinical trials for new medicines is an expensive matter. In an attempt to establish world-wide standards, the industry in the major territories of the EU, Japan and the US co-operated with their regulatory agencies through the International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH) to establish a unified approach. Establishing the same standard through the ICH process has meant a movement to the highest common factor in defining guidelines and standards adopted. This has also meant adopting the highest standard for pedantry in documentation, something anyone involved in clinical research will surely already have noticed.

In the clinical field these guidelines cover Good Clinical Practice, which includes staff-intensive processes of double-checking all data points, general principles of trial design, statistical principles and a complex guideline for the structure and content of clinical trial reports. As the level of required bureaucracy grows, small research units find themselves unable to provide data that would be accepted by regulatory authorities to agree or change indications [2]. As the need for speed in obtaining positive and statistically significant results becomes ever more critical to companies, which are made as transparent and as fragile as glass due to their stock market exposure, the habit of pooling results from a number of identical trials increases. Enter the global CRO with its massive capacity to generate data rapidly and to standardise methodology.

Given the high moral and statistical standard set by ICH guidelines and the presumption that there are only honest professionals working in the companies, does any of this matter? I would argue it does, and will give some examples, including one very near to home, before pursuing this view.

My wife Walli Bounds, also a member of the HealthWatch Committee, was working at the very end of a large development programme for a new type of contraceptive, a hormone-containing vaginal ring. The programme had established substantial data on safety and effectiveness, much of it from research controlled independently by the World Health Organisation and the product was near to market. She noticed some changes in the vagina which might have been adverse reactions to the product and published her results in the usual way [3].

Being "old-fashioned" in the very best meaning of these words, the company's medical advisors did not discourage her publication. They made a video of the technique used so that other investigators who had not before seen lesions in their studies could confirm or deny these findings and evaluate their incidence. The result for them was wholly favourable. They found the problem was not uncommon and deferred marketing the product. By doing so they avoided the possibility of launching a product which might have damaged the health of some users, leading to litigation and perhaps product withdrawal—a true industry nightmare, which can cost millions of pounds and a good reputation.

However, a short term view might be taken by someone with share options, a favoured technique of the open market for rewarding senior personnel. What if the research was subject to a no-publication clause which the company would not relax and the product was critical to the continuing good fortunes of executives whose bonuses depended upon successful launch of the product as forecast to stock analysts?

I am not saying that anything improper would be done; it is not necessary. The data would of course be reported through to the regulatory authority, but could be diluted by being pooled with a very large volume of data not showing such worrying findings. It need not be heavily emphasised in the Expert Report written by the company, intended to guide the regulatory authorities to potential problems, because it was seen at only one centre. In the US where the Food and Drug Administration re-evaluates clinical data and makes a point of studying discrepant findings intensively, the problem might surface; in the EU, where much greater reliance is placed upon the final report, it might not.

Recently there has been a very public row at British Biotech Pharmaceuticals. Open discussion by the medical director about interpretation of trial results was deemed by the directors to involve release of price-sensitive information; the share price collapse certainly showed them to be correct in this respect and they removed him from post. Another view, however, is that open discussion is an essential part of the scientific process. In this case there are more complicated considerations than openness versus disclosure, but the share price collapse shows what pressures exist.

So the general questions must be considered:

- how open can investigators be when the data from their study are considered to be the intellectual property of the company?
- what happens if a medical department is too weak or too frightened to hold their ground?

The first question is easily answered. In a recent episode in the US concerning a study of the comparative bioavailability of different makes of an antithyroid product, years passed before results were published in a way that supported the investigator's view of what they showed.

Traditional company structures, leaving considerable power in the medical department, militate against anything but medically sound decisions on marketing; yet serious errors still have occurred. In the current global company environment, the risk of the decision being distorted by commercial considerations may be increased. Involvement of a CRO introduces further concern. The CRO has a professional duty of care to ensure they report and evaluate matters accurately. However, when payments depend upon rapid reporting of results and their full acceptance by the owner of the product; this introduces another set of complex pressures.

Again, no one need do anything wrong. The more complex the structures, the more price-sensitive the information, the more difficult it is to be independent in judgement. The effect is diffuse and subtle: it only requires a number of requests for re-evaluation of results, for re-writing of Expert Reports, for the penny of self-interest to drop and for results to go the way the financial interest of the company requires. Neo-liberalism is a strange word for a system which can have such an effect; but we have lived long enough to know that self interest has many guises and names do not always carry the meanings that once they did.

It follows that the individual involved in clinical research must be strong and vigilant. He or she must retain full control over information collected and have the courage to defend a reasonable interpretation of what it means. Again, as recommended in the Royal College of Physicians report¹, it is correct to be courteous and obtain the company's opinion before publishing. But in the end, those with clinical responsibility must keep the whistle near to hand and be ready to blow it.

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Michael E Allen HealthWatch Committee Member

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TREATMENTS

Dogs "not psychic" say tests

Pet owners convinced their dog is able to mystically "sense" their imminent arrival from work are probably fooling themselves or, at the very least, barking up the wrong tree, say psychologists.

Dr Richard Wiseman and Dr Matthew Smith of the University of Hertfordshire, together with Dr Julie Milton of the University of Edinburgh, report their findings on the 'psychic pet' phenomenon in the latest issue of the British Journal of Psychology.

A dog, named Jaytee, had previously appeared on television demonstrating its ability to psychically detect when its owner was returning home. The research team set out to test this ability scientifically.

The scientists set up well designed experiments to eliminate plausible explanations, such as routine responding, hearing or smelling the owner at a distance, and selective memory. The result was that in four different experiments Jaytee failed to detect accurately when his owner set off to return home.

"A lot of people think their pet might have psychic abilities," said Dr Wiseman, "but when we put it to the test, what's going on is normal not paranormal."

Reference

Can animals detect when their owners are returning home? An experimental test of the 'psychic pet' phenomenon. Wiseman R, Smith M. British Journal of Psychology 1998; 89 (3): 453-462.

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Magic, magnets and mind over matter

This year's silly season saw a glut of complaints upheld against advertisements promoting unusual health products and services. The August issue of the Advertising Standards Authority's Monthly Report contained deliberations on claims involving electricity, magnetism, slimming patches, and even "mind over matter".

"We need magnetism like we need food and water" was amongst no fewer than ten dubious claims against which complaints were upheld following a direct mail campaign designed to promote "Magno-pulse", a magnetic device to be worn on the body to alleviate problems such as arthritis, gout, migraine and heart problems. The ASA had to explain to the advertisers, Chippenham company Cromhall Farm, that testimonial letters from customers alone do not constitute substantiation of claims. The same company was meanwhile also defending itself against complaints about their advertisements for a similar device to be worn by horses. Again, the complaints about claims for efficacy in treating tendon injuries, laminitis, splints and so on were upheld in the absence of suitable substantiation.

Beauticians' evidence rejected

Six complaints were upheld against a magazine advertisement for London company Beautiko Ltd's "Magic Face" electromuscular stimulator. The advertisers offered testimonials from two beauticians to support claims made for the device, which was claimed to "give a complete facelift by exercising and toning facial muscles". But because no appropriate scientific evidence was submitted the ASA considered the claims unsubstantiated.

On the other hand Body Profile (UK) Ltd, whose advertisement for their Gézanne Facepure Anti-Wrinkle System also claims to give a non-surgical face-lift, did not even respond when they were asked to demonstrate their product's efficacy.

Slimming patches were back in the news, this time from Dayonne Bioslim Research & Development. Claims that Slim Patch gives you "The Amazing Power TO BE SLIM AND STAY SLIM" as well as reducing fatigue and cholesterol resulted in the advertisers being asked to withdraw the mailing immediately.

See also: [Newsletter 13](#), Autumn 1993; [Newsletter 24](#), [Newsletter 24](#), February 1997; [Newsletter 26](#), July 1997

A seminar on healing, promoted as "AN EXCEPTIONAL OPPORTUNITY TO ADD MAJOR ADDITIONS TO YOUR HEALING SKILLS" was promoted by John Howard of Northampton using a leaflet that claimed "trapped nerves...dislocations can all respond—and mostly in only minutes" and that "one in eight prescriptions written by Doctors are for sugar related conditions." The advertisers were asked by the ASA to modify their advertisement so that it did not imply their methods had been shown to benefit health.

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MEETING REPORT

Stopping the clock?

A conference about Positive Ageing John Garrow, HealthWatch's Chairman, and newsletter editor Mandy Payne were amongst the packed audience at a recent meeting organised by the Guild of Health Writers. They didn't learn the secret of eternal youth, but there was a good deal of clinical, down-to-earth information to be had. Mandy Payne reports.

Scanning the lengthy guest list while registering for "Stopping the Clock?" one couldn't help wondering whether women's magazine readers are due for an avalanche of advice on wrinkles, creaky joints and liver spots around October. Happily, any advice written by journalists attending this meeting should be pretty sound. Speakers were distinguished and, though the material was interesting, there was little hype and flash.

Introducing the meeting, psychiatrist Dame Fiona Caldicott, Principal of Somerville College, set the tone by running through some common media-generated misconceptions about health and stressed the importance of getting accurate information to the public. This was clearly to be an evidence-based evening.

First onto the stand was Tom Kirkwood, Professor of Biology of Gerontology at the University of Manchester with a thorough, if (necessarily) fast-paced, talk on the biology of the ageing process—why it is inevitable, why different creatures have different lifespans, the role of genes and to what extent we may one day be able to stall certain aspects of the process.

We barely had time to draw breath before Professor Jeffrey Blumberg of Tufts University Boston in Massachusetts began to explain the evidence for links between environment—specifically diet and exercise—and disease. This, like the previous talk, was highly technical. No danger of making experienced medical writers feel patronised here. A short break was followed by talks on HRT by Howard Jacobs, Professor of Endocrinology, and on skin ageing by Professor Nicholas Lowe, dermatologist of London's Cranley Clinic. Facts, figures, and no miracle cures for the beauty pages.

The light entertainment was supplied by Dr David Weeks, Head of Old Age Psychology at the Royal Edinburgh Hospital, as he described the results of his survey of the "super-young"—those types who refuse to let their advancing years stop them from learning to windsurf or such like. As he described their distinguishing features (including a positive outlook, regular exercise and robust sex life) pens scribbled away madly (ours included).

Sadly, a technical hitch sabotaged what should have been a fascinating and thought-provoking finale on Mind/Body Medicine—the implications on health of patterns of heart rhythm variability. Dr Alan Watkins of

Southampton General Hospital's School of Medicine, was let down by his computer software and the demonstration (involving a volunteer being monitored while her trace was shown projected onto a screen) fell into disarray.

It was certainly a good idea to begin the meeting at 5pm—so many press events are poorly attended because guests just can't spare the time from a busy working day. But fatigue was soon setting in (aided by the very tasty food and wine supplied) and we slipped away before 9pm, so missing the panel discussion.

The event was, we were told in small print, sponsored by Solgar Vitamins. All credit to them for their generosity—there was no promotional material whatsoever in evidence, not a product or even so much as a logo to be seen, whether at the venue or in the press information pack.

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Favourite quotes—send us yours

The following items were recently sent in to the editor by HealthWatch members:

"Exaggerated claims for the efficacy of a medicament are very seldom the consequence of any intention to deceive; they are usually the outcome of a very kindly conspiracy in which everybody has the very best intentions. The patient wants to get well, his physician wants to have made him better, and the pharmaceutical company would like to have put it into the physician's power to have made him so. The controlled clinical trial is an attempt to avoid being taken in by this conspiracy of good will."

P B Medawar, in *Advice to a Young Scientist*, Harper & Row (1979).

"...I don't doubt for a moment that if NHS GP's were given the wherewithal to send us all off to alternative practitioners we would feel happier and healthier for it. But I'm equally sure that if the same money was spent on allowing GP's to spend more time with us, listen to our problems and occasionally send us all off to have our feet massaged for the sake of it, we'd feel just as happy and probably even healthier still."

John Diamond, writing in the *New Statesman* (29th May 1998).

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INTERNET Sites to see

There's a hoard of useful links at the new web site set up by MaLAM, the Medical Lobby for Appropriate Marketing. MaLAM aims to encourage pharmaceutical companies to provide reliable and trustworthy information. As well as letting you download talks and articles about the marketing of pharmaceuticals, the site includes a vast number of links to consumer organisations, sources of drug information, journals and pharmaceutical industry sites. You'd expect a bias towards Australian information, because MaLAM has been given access to the server at Flinders University, South Australia free of charge by the Australasian Cochrane Centre based there. But in fact there are plenty of links to UK, Europe and USA sources. Find it at www.camtech.net.au/malam.

If you're interested in whether an ad is following the rules, check at the Advertising Standards Authority web site. The British Codes of Advertising and Sales Promotion are given in easy to follow sections, there are facts and figures on complaints, and archives of adjudications made against advertisers since January 1997. Unfortunately you can't vent your frustration against an ad by e-mail—the ASA ask that all complaints continue to be submitted on old-fashioned pen and paper. View the site at www.asa.org.uk.

While away ridiculous amounts of time visiting the famous Quackwatch site. Retired US psychiatrist Stephen Barrett has compiled dozens of feature articles about every imaginable kind of alternative therapy and, as well as including links to sites providing reliable sources of consumer reference information, he has also given equally extensive lists of "non-recommended" sites, books, and "experts". Cancer patients have a section all to themselves, containing articles with titles such as "25 ways to spot quackery" and "Ploys that may fool you." Explore on www.quackwatch.com.

Compulsive dictionary browsers will quickly become engrossed in HealthCare Reality Check, a site run by the US Georgia Council Against Health Fraud. Their dictionary link has definitions to 1,200 "metaphysical healthcare methods". A glance under the letter "C" explains all you ever wanted to know about "candle magick", the "Cayce Diet", "Celestial Soul Clearing" and much, much more. It's at www.hcrc.org.

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Web doctor

HealthWatch Committee member Dr Andrew Herxheimer was recently contacted for advice by a woman who had got his name and telephone number from a web page. She had been prescribed a Bach flower remedy by a private doctor. Finding it no use, she'd asked the pharmacist what it was (the label didn't say). He said he couldn't tell her without the doctor's agreement.

"I suggested asking the doctor, on the grounds that it had not helped and she needed to know so that if she were offered it again by someone else she could decline the offer," said Dr Herxheimer. "If the doctor then did not tell her what it was, she would have grounds for reporting him to the General Medical Council, and should do so."

Do any other readers have similar stories about the prescribing of complementary medicines without adequate information?

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