

## Newsletter no 32: January 1999

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## Award to Polly Toynbee

*Leading journalist Polly Toynbee was the winner of the 1998 HealthWatch Award for her outstanding contributions in informing the public throughout her career. Ms Toynbee was unable to accept the award in person at this year's Annual General Meeting, but she prepared for us the following report of her views on issues that concern HealthWatch, ranging from health screening to bogus diagnostic techniques.*

*Questions were put to Ms Toynbee on HealthWatch's behalf by Chairman Professor John Garrow. He began by asking whether she believed that screening programmes involving apparently healthy people do more good than harm? She replied, "As a member of the National Screening Committee, we are bombarded with requests for national screening programmes for a huge variety of ailments, some of them utterly esoteric and rare.*

"There are currently several hundred haphazard screening programmes in operation, done differently or not at all in different areas, many of them of deeply dubious quality or purpose, many quite expensive. It is plainly going to take time and a lot of persuasion from the centre to get people to stop doing what they have done for a long time, where there are no clear beneficial outcomes. It is much harder to stop existing screening schemes than it is to start new ones.

"We started out two years ago and have now drawn up a protocol with which to judge any proposed - or existing - screening programme.

"The key principles are that the screening should be for a relatively common disease, that the process should be easy to carry out, will gain public support, a high quality should be maintainable, and that there should be a clear remedy with a definite health gain if disease is detected. The test should provide an acceptable level of false positives and negatives, and people should understand that there will always be some false positives and negatives. Every programme should have a strict quality assurance and effectiveness evaluation built into it. Cost is one element in the consideration, but it is by no means the overriding one. One of the first requests we dealt with was for prostate cancer screening. A huge head of medical pressure had built up for this procedure amongst urologists. There was also quite a strong political pressure from the small but vocal nascent men's movement who felt men should have the same access to screening as women did for breast and cervical cancer. This was the first real test of our resolve to stick by the principles we had drawn up, for prostate screening failed on several counts. The most important of these was that it was still unclear whether if prostate cancer is detected, surgical intervention makes any difference to the outcome. Prostate cancer is found in a high number of older men who will outlive their disease, and surgery can damage their quality of life without offering a clear health gain.

"On the other hand, we have decided to go ahead with pilot schemes to test out the effectiveness of screening for bowel cancer. Catching it early has very clear health gains in saving lives, but the pilot will show what level of compliance it gains from the public who have to take part in a test many of the squeamish may find unacceptable. In my view, the work of the committee is very thorough, properly analytical, and well aware that the anxiety which can be caused in screening programmes—and the money wasted—can end up causing the individual and the NHS more harm than good. There is a strong push for screening for every disorder, so we regard it as most important to try to educate the medical profession and the public on the principles of screening. Our work is as public as possible and all papers are available on our own web site on the Internet."

**"Unvalidated methods of healthcare in conventional/alternative medicine. Is this a great evil to be rooted out? If so, how? Or should we apply *caveat emptor*?"**

"Personally, I am appalled at the galloping growth in belief in 'alternative' health. Alternative only means anything which hasn't been properly subjected to clinical trials. Prince Charles keeps trying to bring together orthodox and unorthodox methods. Newspapers that thirty years ago would have had no truck with this now peddle it daily on their health pages—especially the Daily Mail—alongside articles on real health care. It is strange and alarming to me that just as more people are being educated for longer, many more doing sciences at least until the age of 16, the world seems eager to abandon basic scientific methods in favour of alchemical mumbo jumbo.

"As a first step, there should be a strict edict within the NHS that no unvalidated method should ever be part of the health service. (This might not include osteopathy: for all its weird underlying beliefs, there is good evidence of its efficacy, but only in the first six weeks of back pain—not for chronic long - term conditions.) If the NHS, from the department, took a firm and public stand on this, we would at least start the debate. The Department for Education should take the same view where it is creeping into university courses—usually new universities—often with sponsorship from the makers of herbal and homoeopathic remedies.

"I don't think 'caveat emptor' is enough here, when so many newspapers and magazines tell people unscientific stories about miracle cures. Perhaps all remedies, and peddlers of them, should have to tell patients clearly that their quackery has not been tested scientifically. After all, some agents such as ginseng (though goodness knows why only one or two) are specifically banned under Advertising Standards rules from claiming any health - giving properties whatever. Alas, people still take it!"

**"When a procedure is shown to be completely bogus (e.g. iridology or applied kinesiology as a method of diagnosis) this hardly affects the popular demand for it. Why is this so? Does it matter?"**

"Why do people cling to bogus procedures? Because they want to believe in magic and miracles. And many hate and fear doctors for phobic reasons. Some people who are well want to think themselves ill, or that they are suffering from interesting allergies, to shore up their view of themselves as more interesting people. Or simply because they are emotionally in need of feeling someone is caring for them. The one bit of good the alternative practitioners may do is to take troublesome patients off the hands of hard - pressed doctors. But obviously that has risks, since some of these patients may be ill with real diseases not at first detected."

**"Is there inevitably a conflict between a scientific approach to medicine and a loss of the holistic approach? Does it matter?"**

"I don't think there's any reason for the holistic idea to be exclusive to alternative practice. We all know doctors who are good scientists and horrible to patients, and vice versa. Increasingly patients won't tolerate rude and unkind doctors, and tend to walk with their feet, if they can. Amongst younger doctors these days I'm much encouraged to hear them talk a great deal about the good they can do by treating people well, listening to them and treating them as a whole person, not as a body-part.

**"Clearly medical schools have become far more aware of this aspect of treatment. Also, increasing use of counsellors within GP practices can do much to help."**

"Will evidence - based medicine destroy the efficacy of placebo treatment in situations (e.g. multiple sclerosis) in which a good placebo is the best treatment on offer?"

"Evidence-based medicine is the only way forward and the government's new National Institute for Clinical Effectiveness ought to do much to weed out treatments that don't work and encourage those that do. It ought, in the end, to give people more, not less, confidence in their doctors.

"The placebo effect is very powerful, and good doctors know how to use it to suit each of their patients. Some patients are scientifically minded, others just want to trust their doctor blindly. Oddly, in my experience, this has nothing to do with intelligence or education, but is an attitude of mind people adopt when faced with serious illness. Some rush out to read every book, others prefer trust and hope, or simply mentally avoid it altogether. But once we elevate the placebo effect above science, all is lost."

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## Corrected promptly, with due prominence

On 8th March 1998 the *Sunday Telegraph* published an item under the heading:

**"Passive smoking doesn't cause cancer—its official."**

The text below said that the World Health Organisation (WHO) had withheld from publication a study which shows that not only might there be no link between passive smoking and cancer but that it could even have a protective effect. BBC Radio 4 picked up this remarkable item in the review of the day's papers, and passed it on to the listening millions, and other media also took it up.

Item 1.ii of the Code of Practice of the Press Complaints Commission (PCC) says that whenever it is recognised

that a significant inaccuracy has been published it must be corrected promptly and with due prominence. The Sunday Telegraph story was "a significant inaccuracy". If the editor of that newspaper did not know it at the time he was soon told. The WHO issued a press release the next day with the message, "Passive smoking does cause cancer, do not let them fool you." The Lancet (of which the Sunday Telegraph receives a complimentary advance copy) ran an item (March 14th, p 807) and a lead editorial (March 21st, p 845) pointing out that the basis for the report was an unpublished (not withheld) report which showed that in a study of 650 non - smokers the odds ratio of lung cancer was 1.16 (i.e. risk 16% greater) in people who had been exposed to environmental tobacco smoke compared with those not so exposed. Because this was a relatively small study the 95% confidence interval (CI) for the odds ratio was 0.93–1.44. This means that the best guess was that the risk was increased by 16%, but statistical uncertainty was such that, on the basis of this study alone, the risk might be anything from 0.93 to 1.44. Another much larger analysis had been published in the BMJ (18th October 1997, p 980 - 988), based on 4,626 cases, in which the best guess for the extra risk of passive smoking was 1.24 (24% greater) but with CI of 1.13–1.36.

There is no conflict between the two reports: both show an increased risk in passive smokers of about 24%, but the statistical power of the BMJ report was greater, so a risk below 1.0 (i.e. a protective effect) could be ruled out, but in the smaller WHO study the protective effect was still statistically possible. We awaited for the Sunday Telegraph to correct its mistake, but in vain. ASH (the anti - smoking lobby) and HealthWatch independently wrote to the PCC on 25th March asking for the prompt and prominent correction. The error was certainly "significant", since the policy of non - smoking in public buildings and transport was largely justified on the basis that the public were put at risk by passive smoking. The PCC eventually adjudicated on the offending article at a meeting on 21st October 1998: their gestation period was therefore over 32 weeks. While the PCC was pregnant with this problem the full study had been published in a scientific journal, so the Sunday Telegraph had triumphantly published an article headed "Study fails to link passive smoking with cancer" saying (correctly) that "the scientists had found a 16–17% relative risk of contracting lung cancer if you lived or worked with a smoker, but that this was statistically non - significant." The adjudication to which the PCC gave birth was not premature, but was curiously malformed. The complaint with which they were dealing was that the headline said, "Passive smoking doesn't cause cancer—official." This was plainly untrue, since WHO, the Chief Medical Officer, and everyone else who understood statistics agreed that an odds ratio of 1.16 (CI 0.93–1.44) meant that passive smoking probably increased the risk, but in this study it as not possible to show where the risk lay in the range of 0.93 to 1.44. It did not suggest that passive smoking was protective.

The Commission approached the problem in a curiously indirect manner. They "noted that the salient part of the complaint related to an allegation that the newspaper misleadingly reported the contents of the summary of the study." The Sunday Telegraph had now published the summary in full. The PCC therefore considered that the substance of the complaint by ASH had been resolved, and did not uphold the complaint.

**"Water under the bridge," you may say and, "whoever would expect editors to regulate themselves?" Who indeed: but the problem has not gone away.**

In the November 1998 issue of The Oldie (p 6–7) there was an editorial note saying that WHO had published research showing that passive smoking did not cause lung cancer, as the Sunday Telegraph had reported. ASH had complained, but the PCC had ruled that the Sunday Telegraph's reporting was fair. The Oldie therefore reproved ASH, saying their behaviour was "sad, because the case against smoking was strong enough, without having to misrepresent the facts." So now The Oldie has told its readers that WHO research shows that passive smoking does not cause lung cancer, which is a significant inaccuracy, but I am not sure at I can bring myself to write to the PCC again to complain.

John Garrow

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## NEWS: JAMA puts the alternatives to the test

*The entire November 10th 1998 issue of JAMA, the Journal of the American Medical Association was given over to alternative medicine and in the same week 60 more articles on related topics were published in nine of the Association's other respected journals.*

Dr. George Lundberg, JAMA's editor, was responding to demand from doctors who wanted scientifically sound data on treatments and products that so many patients were asking about.

Of the seven research studies published in JAMA, three showed alternative treatments to be useless. Lundberg told a news conference that the mix of positive and negative results resulted by chance, not editorial design.

Researchers found good results using a mixture of 20 or more Chinese herbs for irritable bowel syndrome; the herbal product saw palmetto for bladder symptoms caused by prostate enlargement; yoga for the wrist pain and other problems caused by carpal tunnel syndrome, and—inexplicably—the use of the ancient Chinese practice of moxibustion for encouraging fetuses in the breech position to turn in the womb. This latter involved the burning of a cigar - shaped roll of herbs near an acupuncture point on either little toe of a pregnant woman. After two

weeks of treatment, 75.4 percent of the babies in the moxibustion group had turned, compared with 47.7 percent in an untreated group.

Treatments found not to work included chiropractic manipulation for tension headaches, the herb *Garcinia cambogia* for weight loss and the use of acupuncture to control pain from nerve damage caused by HIV, the virus that causes AIDS.

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## Supplement ads still questionable

***A third of advertisements for vitamins and supplements surveyed recently were found to be questionable or in breach of ASA guidelines.***

Researchers from the Advertising Standards Agency had scrutinised 162 ads for dietary supplements to check their compliance with the British Codes of Advertising Practice and Sales Promotion. The result of the survey was particularly disappointing, say the ASA, because it showed there has been no significant improvement since a similar survey in 1997 found that 35% of supplement ads broke the Codes.

When advertisers were contacted and asked to provide evidence to support questionable claims, most were unable to do so.

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## Echinacea fails the cold challenge

***German scientists could find no significant benefit in using the herb Echinacea to prevent colds, they report in a recent study.***

Echinacea is commonly taken to "boost the immune system" with a view to preventing colds and other respiratory infections. In a twelve week double - blind placebo - controlled trial the Munich researchers gave 302 healthy volunteers either *Echinacea purpurea* or *Echinacea angustifolia* root extracts, or a dummy pill, and noted any effect on prevention of upper respiratory tract infections.

Subjects taking a herbal extract lasted slightly longer before succumbing to infection and got slightly fewer colds than those given the placebo, but the differences were not significant.

Reference: Arch Fam Med 1998; 7: 541-5.

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## HealthWHICH? exposes food allergy testing

***At best, food allergy testing services are a waste of money. At worst, they're dangerous, concluded Health Which? recently.***

The Consumers' Association publication looked at four services, costing from £20 to £105, that test for food allergy or intolerance. Five researchers, three of whom had known allergies, tried out each testing service twice.

Despite often referring to themselves as "allergy testing" services, they either completely failed to spot the researchers' allergies or claimed they don't deal with allergies at all. The vast majority of results for the same person tested twice by the same service did not match up and, compared with each other, the testing services came up with "greatly different results".

The CA's experts concluded that the tests could not reliably diagnose true food allergies or intolerances and, in the cases where known allergies were not identified, the test could be "positively dangerous".

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## Sceptical views heard on Sky TV

***"Alternative medicine: is it alternative in the sense that it doesn't cure you?" joked presenter Jayne Irving as she introduced a recent episode of Sky TV's "Living Issues" programme which devoted half an hour of studio discussion to the subject of alternative medicine. In fact the guests included a number who believed they had, indeed, been cured by alternative or complementary treatments.***

Among them were broadcaster Gloria Hunniford whose homoeopathic treatments had avoided, she said, the need for surgery to a damaged humerus; businesswoman Dounne Alexander whose pet dog's cancer disappeared after being given a herbal remedy; and TV presenter Amanda Cross whose massive inoperable tumour vanished without trace following hypnotherapy and faith healing.

The programme wasn't a wholesale attack on conventional medicine. All present agreed, and the point was repeatedly stressed, that we were talking about treatments that complemented, rather than replaced, orthodox medicine. All the "cured" had also received conventional medical treatment. Barry Blatt, a sceptical Nursing Times journalist pointed out that Ms Cross's tumour was more likely to have been cured by the radiotherapy she received, not because complementary treatments powered up her immune system to fight back, as she seemed to believe.

In the sceptics corner, Blatt was accompanied by Exeter University's Dr Adrian White, who spoke up for the clinical testing of complementary therapies, and young mother Patricia Moore whose husband had been less fortunate than her fellow guests. In the agonising throes of terminal cancer he had refused painkillers in the mistaken belief that his tumours had been "de-materialised" by a psychic surgeon.

It is impossible to watch talk shows without constantly wondering what each person would have said if they'd been given the time to finish making their point. This one was no exception. But some good points were made nevertheless, not least the fact that there may indeed be some medical benefit to be had from treatments that do no more than make you feel more positive or cope better with a tough prognosis (that is, placebos)—a fact that conventional doctors have always known. And the final point, made by Patricia Moore just before Irving wound up the discussion, that sometimes diseases just resolve themselves for no reason.

There was a last minute contribution from a viewer who'd phoned in to say that her young son's tonsillitis had "virtually" cleared up in just four months while he'd been taking a course of homoeopathy. To me, especially coming immediately after Mrs Moore's parting shot, it sounded a perfect example of a condition just running its course and getting better of its own accord.

Mandy Payne

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## CHAIRMAN'S REPORT : Working with other organisations to inform the public

*At HealthWatch's Annual General Meeting, held on 21st October 1998 at The Society of Genealogists, London, our Chairman Professor John Garrow reviewed the results of this year's work with organisations which are, like HealthWatch, concerned with informing the public on healthcare.*

The main function of HealthWatch is to provide reliable information on healthcare, and to refute inaccurate information. This we do primarily through this Newsletter, and the telephone Helpline which is manned by Sheila Smith and Prof Vincent Marks.

An important new development in 1998 was the setting up of our web site, courtesy of Dr David Bender of University College London. This has made HealthWatch better known (especially through links to other web sites related to healthcare) and also gives journalists access to the index of topics covered in past issues of the Newsletter, and abstracts of material in current Newsletters. This year your committee has tried to work with other organisations which also provide healthcare information to the public. Examples are listed below:

- **Radio and television** HealthWatch has been represented on Woman's Hour, Natural Born Healers, Esther on Faith Healing, Carlton TV on fat. However the media are not obliged to appraise scientifically (see BMJ, 10th October 1998, 317: 1023 on risk factors for coronary heart disease).
- **Advertising Standards Authority** gave clear and prompt judgements in response to our complaints about Chelation Therapy, Efavprost.
- **Parliamentary Group for Alternative & Complementary Medicine** meetings give uncritical support to alternative practitioners "too busy" to test methods scientifically.
- **FACT**: Focus on Alternative and Complementary Therapies, the newsletter prepared by Professor Edzard Ernst at the University of Exeter.
- **Foundation for Integrated Medicine** see Dr Thurstan Brewin's review of their report (HealthWatch [Newsletter no 30](#), July 1998).
- **Royal College of Nursing's Forum on Complementary Medicine** goodwill exchanged, but no progress on testing therapies.
- **Royal College of Complementary Medicine, and Health Which?** politically delicate questions raised, for example, who should fund trials of therapies such as kinesiology? But they do investigate questionable practices (headache cures, slimming clinics).
- **Trading Standards Officers** effective in fraudulent cases, but very labour intensive.
- **Press Complaints Commission** rule that "significant inaccuracy" be "corrected promptly and with due prominence", though we have not found this to be the case, see our report on coverage of a study on passive smoking on the [front page of this issue](#).

*In summary, there are many organisations which aim to provide the public with information about healthcare but, for various reasons, none has the same ability and freedom as HealthWatch to evaluate conventional or alternative methods in an unbiased manner. We occupy this privileged position because we have no employers or customers whose commercial interests we must protect. That in turn arises because our income is from the charitable donation of our members, or outside charities, and because the work is done by members who give freely of their time and expertise without payment.*

I am very grateful to have the opportunity to work in an organisation such as HealthWatch, and very grateful to all the people who give so much practical support to our activities.

John Garrow

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## Are highly dilute homeopathic remedies placebos?

*Edzard Ernst, Professor of Complementary Medicine at the University of Exeter, has kindly given permission for us to reprint this article, which appeared in the journal *Perfusion* (dated November 1998, pages 291–2).*

homeopaths believe that “potentized” remedies, which can be so dilute that they contain no molecules of their original ingredients, have specific effects (i.e. effects beyond placebo) in almost any medical condition.

Even though 200 years old, homeopathy has remained highly controversial [1]. A meta-analysis of all placebo-controlled and/or randomized trials of homeopathy recently concluded that the clinical effects of homeopathy are not completely due to placebo [2]. In the view of many, this statement shakes the fundamentals of science. The aim of this study was to re-evaluate these data using different, stricter entry criteria.

### Methods

The data of Linde et al, as presented in their meta-analysis, were used [2]. The present re-evaluation was confined to such studies which received a rating of 90 (out of a maximum of 100) points in at least one of the two rating systems used by these authors<sup>2</sup> for assessing methodological quality of the studies. Moreover trials were excluded if they were

1. not on highly dilute (thus still containing molecules of their “mother tincture”),
2. conducted on complex (non-Hahnemannian) mixtures which are not administered according to the ‘law of similars’,
3. were on isopathic (e.g. potencies produced from allergens as a treatment for hayfever) rather than truly homeopathic medicines (i.e. based on Hahnemann’s “like cures like” principle).

The data are expressed as odds ratios and 95% confidence intervals, in the same way as in the original publication of Linde et al [2].

### Results

Five trials [3, 4, 5, 6, 7] fulfilled all of the above inclusion and exclusion criteria and were analysed. All studies were conducted on patients suffering from different conditions. In total they comprise 587 patients. Only one of the trials [4] yields a significant result—in this case in favour of homeopathy. One further study shows a positive trend, while two demonstrate a negative one. The overall odds ratio equals 1. In this re-analysis, homeopathic remedies are associated with the same clinical effects as placebo.

### Discussion

In science, it is virtually impossible to prove a negative. However, these data seem to come close to establishing that “true” (as defined by the above criteria) homeopathic remedies are, in fact, pure placebos.

The difference between Linde’s [2] and the above findings are striking. Clearly they are the result of the difference in selection criteria for the meta-analyses. Linde et al [2] also notice that, by only admitting “high quality” trials to their analysis, the odds ratio is diminished from originally 2.5 to 1.7. This exemplifies an important criticism of meta-analytic techniques in general [8]—by pooling data of unreliable quality, one will obtain an unreliable result. To put it more bluntly: the meta-analysis of nonsense must result in nonsense.

The question arises as to how justified the chosen inclusion/exclusion criteria are. The debate as to whether or not homeopathic remedies have an effect pertains only to those remedies which are so dilute that they are unlikely to have material (pharmacological) effects. No-one would argue that a homeopathic mother tincture can be effective. Linde et al [2] did include such trials [9]. It is therefore permissible to exclude such studies when addressing the question of effects of high dilutions.

It was argued that “unknown and unidentifiable sources of bias” have contributed to Linde and co-workers’ findings [10] and that the inclusion of non-randomised studies was “misleading”<sup>11</sup>. The best way to minimise the possibility of bias is to apply the strictest possible criteria for methodological quality. This was done for the

present analysis by excluding trials which scored less than 90%.

Neither complex homeopathic remedies which are a fixed mixture of a variety of compounds aimed to treat a given symptom, nor isopathic remedies can be legitimately called homeopathic as they do not follow the 'law of similars' which is the core tenet of homeopathy. Hahnemann himself called therapists deviating from pure homeopathy in the slightest way "traitors" and left no doubt that only his type of homeopathy was effective [12]. Today several other schools of homeopathy abound. It is logical to scrutinise each on its own merit. The present analysis is confined to classical Hahnemannian homeopathy which, in the view of most homeopaths, is the true and clinically the most successful type [13].

The publication of the meta-analysis by Linde et al in the Lancet [2] led to a furore of editorial comments in many of the leading science journals world-wide. The Lancet published no less than two Editorials [10,14] and nine "letters" on this subject [15]. The present re-analysis suggests that much of this debate was futile—applying strict criteria, a meta-analysis of dilute homeopathic remedies shows no effect over placebo whatsoever.

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#### References:

1. Ernst E, Hahn E (eds). homeopathy: a critical appraisal. Butterworth Heinemann, Oxford 1998.
2. Linde K, Clausius N, Ramirez G, Melchart D, Eitel F, Hedges LV, Jonas W. Are the clinical effects of homeopathy placebo effects? A meta-analysis of placebo-controlled trials. Lancet 1997; 350: 834–43.
3. Labrecque M, Audet D, Latulippe LG, Drouin J. homeopathic treatment of plantar warts. Can Med Assoc J 1992; 146: 1749–53.
4. Jacobs J, Jimenez LM, Gloyd SS, Gale JL, Crothers D. Treatment of acute childhood diarrhea with homeopathic medicine: a randomized clinical trial in Nicaragua. Pediatrics 1994; 93: 719–25.
5. Hofmeyer GJ, Piccioni V, Blauhof P. Postpartum homeopathic Arnica montana: a potency-finding pilot study. Br J Clin Pract 1990; 44: 619–621.
6. de Lange de Klerk E, Blommers J, Kuik DJ, Bezemer PD, Feenstra L. Effects of homeopathic medicines on daily burden of symptoms in children with recurrent upper respiratory tract infections. BMJ 1994; 309: 1329–32.
7. Lökken P, Straumsheim PA, Tveiten D, Skjelbred P, Borchgrevink CF. Effect of homeopathy on pain and other events after acute trauma: placebo controlled trial with bilateral oral surgery. Br Med J 1995; 310: 1439–42.
8. Smith GD, Egger M. Unresolved issues and future developments. BMJ 1998; 316: 221–5.
9. Ernst E, Saradeth T, Resch KL. Complementary therapy of varicose veins—a randomized, placebo-controlled, double-blind trial. Phlebology 1990; 5: 157–63.
10. Vandembroucke JP. homeopathy trials, going nowhere. Lancet 1997; 350: 824.
11. Jahrmärker H. Homöopathie. Dtsch Ärztebl. 1998; 95: C–101.
12. Ernst E. The heresy of homeopathy. A brief history of 200 years of criticism. Br Hom J 1998; 87: 28–32.
13. Vithoulkas G. The question of provings in homeopathy. FACT 1998; 3: 27–8.
14. Langman MJS. homeopathy trials, reasons for good ones but are they warranted. Lancet 1997; 350: 825.
15. Multiple authors. Meta-analysis of homeopathy trials. Lancet 1998; 351: 365–8.

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## The need to compare results

*For many critically ill patients, for example after extensive burns, the circulation shows a lower level than normal of an important protein—albumin. So it seems logical to correct this.*

And sure enough, injecting albumin into the blood stream has been fairly standard treatment in many situations for many years. Some concerns have been expressed, but it seems that most clinicians have had no doubts.

So it was quite a bombshell when the BMJ [1] gave maximum prominence to a report, based on a careful review of all available randomised trials (each trial comparing giving albumin with not giving albumin) which concluded, **"There is no evidence that albumin administration reduces mortality in critically ill patients and a strong suggestion that it may increase mortality"**.

**Here we have eloquent testimonial of the need, constantly urged by HealthWatch, for more comparisons of outcome after different interventions.**

Moreover in spite of some fairly bitter criticism of the report in letters to the BMJ from those regularly giving albumin to critically ill patients, not one of them provided any solid evidence that doing so was in fact beneficial. And Iain Chalmers, HealthWatch member and Director of the Cochrane Centre commented in his letter, "I am not aware of any instance in which a systematic review of controlled trials suggesting that a form of care increases

mortality, has been followed by a controlled trial that the intervention concerned actually reduces mortality." As often happens, the anger shown by those who had felt they were only doing their best for their patients was made even worse when the press picked it up and said that albumin was "killing" people. Not quite the right phrase, I would have thought, when these patients were already critically ill and when there was only the probability, not the certainty, that their chance of recovery was statistically slightly reduced. But that's the media for you. And some doctors would think the phrase was justified.

With any treatment of any kind, in any condition, overall lack of benefit in a large series (compared with a control series) cannot exclude the possibility that among them are some who did benefit. Even overall harm can conceal benefit to a few. Likewise overall benefit can conceal some harm. This can happen either because of small subgroups that react differently or because of the individual variations that occur in all living things. But as Bradford Hill pointed out thirty five years ago [2], overall results are the best we can do. Large numbers are needed to be reasonably sure of small differences. And it's a sobering thought that for many years albumin has been widely believed to be a vital part of many treatment programs. It will be difficult for anyone to see it like that now.

In any condition, medical or surgical, when we try to figure out the best options for the individual, the overall results of randomised comparisons are never more than part of the picture but they are a pretty important part. And, turning from the individual to society, the question is can we really afford expensive treatment for so many patients when the evidence for benefit just isn't there?—to say nothing of the suggestion of harm.

Nearly thirty years ago, basing treatment too much on theory was said by John Todd in an essay in the Lancet [3] to be one of medicine's cardinal mistakes. We need to know, when giving a treatment, not what the effect ought to be according to some attractively plausible argument, but what it actually is, compared with not giving it.

Thurstan Brewin

#### References

1. Cochrane Injuries Group Albumin Reviewers. Human albumin administration in critically ill patients: systematic review of randomised controlled trials. *BMJ* 1998; 317: 235-240.
2. Bradford Hill A. The clinical trial. *Practitioner* 1963; 190: 85-90.
3. Todd J. The errors of medicine. *Lancet* 1970; 1: 665-670.

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## MEDIA: Careless talk on mobile 'phone dangers

***HealthWatch continues to be concerned about the way the media often seem to want to frighten people about putative health risks. Dr Neville Goodman sounds off about the latest in a series of mobile 'phone panic reports.***

Any new technology is bound to come under suspicion. Obvious health risks can be thought of and investigated before a technology's introduction but, by their nature, unknown risks cannot emerge until the technology is more widespread.

Mobile 'phones have featured before in the HealthWatch Newsletter ([issue 23](#) October 1996, and [issue 26](#) July 1997) and a recent court case makes it appropriate to mention them again. The case was brought by Roger Coghill, a biologist who has been involved in previous similar stories involving the risks from power lines (HealthWatch Newsletters [issue 21](#), April 1996; [issue 23](#), October 1996; [issue 24](#), February 1997; [issue 27](#), October 1997).

Coghill was trying to force mobile 'phone manufacturers to put a health warning on their 'phones. Abergavenny magistrates dismissed the case (*Guardian* 11 November 1998), but this will not be the last we hear of it: the *Independent on Sunday* has clearly decided to make it a cause célèbre.

"Mobiles are health risk, say makers" was a front-page headline on 25 October 1998 (though what emerged in the story belied the headline). One week later, under the headline "My husband was killed by his mobile" (1 November 1998), the newspaper gave details of three men, including a Lawrence Mills, who developed lymphomas after using mobile 'phones.

So far, the story is following the classic media-scare script. Mrs Mills believes the 'phone caused Lawrence's cancer because he didn't smoke or drink and led a healthy life. Another man said, "There is no reason for me to develop cancer apart from the link with the 'phone." The media and interested lawyers are no doubt on the lookout now for anyone who has developed cancer, especially lymphomas and brain tumours, since starting to use a mobile 'phone. In fact, for most cancers, the reasons that any particular individual contracted their disease is simply not known. We all look for reasons, but just because one event occurs after another does not mean the first caused the second. There are millions of people who use the 'phones, so it is inevitable that some will have developed these tumours. Other stories in the press have reported people suffering headaches, tinglings, loss of memory, and a myriad of other symptoms common to health scares but unlikely as a group of symptoms



indicative of true disease.

When people become worried, it makes sense to allay their fears. The best way to allay fears is with evidence that the worry is groundless, so an enquiry or research project is established. Inevitably, the next scene in the scare script is that the setting up of the enquiry is taken as evidence that there is a risk. This is the state of play at the moment.

To quote from the website of the [US National Cancer Institute](#), accessed 1 November 1998) "there have been no definitive studies linking cellular telephones to brain cancer, and there is no need to panic". The NCI is undertaking detailed studies of possible links, but even if these links are shown in the future (and I am doubtful that they will be), no manufacturer can be held to blame for risks completely unknown before some future proof.

I wrote a letter to the Independent on Sunday. They thanked me for it, but didn't have room to publish it preferring, presumably, its promotion of the idea that mobile 'phones cause cancer and leave the way open for other "victims" to come forward. At least the Guardian published a letter from Richard Smith (editor of the British Medical Journal) in response to their 14 November 1998 story ("Mobile 'phones get an unhealthy image"), although the Guardian's story had been far more balanced than the one in the Independent on Sunday.

That is not say that mobile 'phones are completely blameless: drivers using them are more likely to have road accidents. Ironically, this was part of a sensible story in the Independent on Sunday's sister daily earlier in the year ("Scientists cast doubt on mobile 'phone dangers", Independent, 3 August 1998).

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