

Newsletter no 44: January 2002

- [AGM](#) welcomes Claire Rayner
- [£10,000 grant application a success](#)
- [News in brief](#)
- [CHAIRMAN'S REPORT](#) Malcolm Brahams reviews a year of growing membership and profile
- [BIOTERRORISM](#) serious threat or damp squib? asks Caroline Richmond
- [CANCER TRAGEDY](#) Dutch CAM devotee dies from untreated breast cancer, Jan Willen Nienhuys reports
- [CLAIRE RAYNER](#) tells HealthWatch members what patients are really for
- [OPINION](#) Matthew Parris considers miraculous cures, beatification, and what they might mean to the rest of us
- Letter: [Fasted if not detoxed](#)
- [PILLS AND POTIONS BY POST](#) David Bender finds claims that might not live up to their promise
- [BOOK REVIEW](#) John Garrow compares guide by Edzard Ernst with Alan & Maryon Stewart's

[Top of page](#)

AGM welcomes Claire Rayner

HealthWatch's Thirteenth Annual General Meeting, and the presentation of the HealthWatch Award to Claire Rayner, took place on 1st November at the headquarters of the Inns of Court City Yeomanry, writes Professor John Garrow, HealthWatch's honorary secretary.

This distinguished building is set among the lawyers' chambers in Lincoln's Inn, whence for centuries the Yeomen defended the Citizens of London from the marauding ruffians from outside the city walls. Today, their fine facilities on the third floor can be hired for use by those who can scale the remaining defences, namely three steep flights of stairs (there is no lift).

The AGM was chaired by Malcolm Brahams, whose report appears [below](#). The membership secretary, Shirley Churchman, had good news of increased membership (to 232 paying members), many of whom joined in response to John Diamond's excellent Award Address last year. John Hanford, treasurer, reported that in the year to 31st May 2001 our income from subscriptions had increased by 32% to £3,625 but donations were slightly lower at £1,217 (compared to £1,901 in 2000), so with added interest the total income was £5,535. Expenditure was also increased to £5,995 (£5,484)—the extra cost being mainly the website, at £510, so again we have a deficit for the year of £460. However, the reserve funds stand at £12,329, so we are not bankrupt, but need to increase income to cover our annual expenditure.

The Executive Committee re-elected were Malcolm Brahams, (chairman), Geoff Watts (vice-chairman), John Hanford (treasurer), John Garrow (honorary secretary), Shirley Churchman (membership secretary), Michael Allen (press officer), David Bender (webmaster), Walli Bounds, Diana Brahams, Neville Goodman, Andrew Herxheimer, Caroline Richmond and Vincent Marks. Neilson & Co were re-appointed as auditors and Joan Gandy and Katherine Garrow as honorary auditors.

Our president, Nick Ross, then presented the 2001 HealthWatch Award to writer and broadcaster Claire Rayner, who delivered an excellent address on "What are patients for?", an edited version of which appears [below](#). Mrs Rayner is an ex-nurse, now an acknowledged authority on child care, medical and allied subjects. She is a formidable campaigner on health and women's issues.

[Top of page](#)

£10,000 grant application a success

Plans for a HealthWatch Student Prize for Protocol Appraisal are now under way following news that the AJAHMA Charitable Trust has generously accepted our application for a grant of £10,000 to fund the scheme.

One of the main objectives of HealthWatch is to promote the proper testing of methods for medical diagnosis and treatment. Usually this should be done by properly designed randomised controlled trials. Unfortunately many practitioners (medical, nursing or alternative) have not been taught enough about the flaws in design that may invalidate the results of such trials. The AJAHMA Trust grant enables us to offer a competition, open to students of medicine, nursing or alternative medicine, who will be tested on their ability to assess the validity of four

hypothetical research protocols. The winner in each class (medical, nursing or alternative) will receive a prize of £500 and a certificate, and up to five runners-up in each class will receive £100 and a certificate.

The AJAHMA trust is a family trust set up in 1977. It supports charities in the fields of medicine, disability, disadvantage, prison reform, women's issues and overseas development. The total annual expenditure of the trust is about £400,000.

[Top of page](#)

NEWS IN BRIEF

British homoeopaths are being flooded with requests from the US for Variolinum and Anthracinum—homoeopathic remedies for smallpox and anthrax. Although there are homoeopathic pharmacies to be found in America, homoeopathy is less accepted there than in the UK, reports The Times, hence the call from across the Atlantic.

Times, 30 October 2001

Despite the hostile publicity it receives when it tries to deny new drugs, the National Institute for Clinical Excellence (NICE) approves many more treatments than it bans, at a net cost to the NHS of around £200m, reported James Raftery, Professor of Health Economics, in the British Medical Journal. Of the 22 technologies on which NICE had issued guidance by March 2001, three were not recommended (with a change of judgement on the new flu drug, zanamivir). The guidance recommending use of the other 19 technologies all cited evidence of clinical benefits, while only around half cited cost, suggesting that economics had a lesser role than evidence of clinical benefits, says Raftery.

BMJ 2001; 323: 1300–3.

US intelligence agencies are recruiting psychics to help predict future attacks and to find Osama Bin Laden, according to a report in the Sunday Times. The recruits, known as "remote viewers", claim to be able to visualise happenings in distant places by using paranormal powers. One psychic group reportedly consulted, Transdimensional Systems, employs 14 such remote viewers and suggest a sports stadium as a likely target.

Sunday Times, 11 November 2001

Chinese herbal medicine has now been linked with kidney cancer, reports the Lancet. Two years ago doctors at Hammersmith Hospital reported on two people who developed kidney failure after treatment with Chinese herbal medicines. Now a routine examination of one of these patients, who had been taking a traditional remedy containing Aristolochia Fangchi for two years before developing kidney failure requiring transplant, has now developed cancer of the ureter. Analyses show the likely cause is aristolochic acid, one of the ingredients of the remedy.

Lancet 2001; 358: 1515.

When 100 Burger King managers took part in a "fire-walking" corporate bonding exercise last year, a dozen left with first or second-degree burns to their feet caused by walking on the red-hot embers, says the Guardian. An expert commented that wood and wood ash are in fact poor heat conductors—keep moving and beds of up to 900°C may not burn; but damp feet or soft woods affect heat transfer and make injury more likely. Furthermore, he added, there is no evidence a positive mental attitude will prevent burning, or that teaching employees circus tricks increases their productivity.

Guardian, 16 October 2001

[Top of page](#)

CHAIRMAN'S REPORT to the Annual General Meeting on 1st November 2001

This year's report is mostly about people. That is as it should be. Without the dedication of the people who run and support HealthWatch, we would not have achieved what we have and would not now be poised to branch out into the new ventures we are planning.

If the AGM is the last activity of year that has passed then the Award is the first activity of the new year. This year certainly began well, when the late John Diamond accepted the HealthWatch Award for the year 2000. If you were not there, you may have read his talk in the [January 2001 HealthWatch Newsletter](#) and many of you will have seen the wonderful article he wrote about HealthWatch in his column in The Times Magazine. That article alone prompted 75 membership applications.

When he died last March, those of us striving for sanity and truth in the reporting of healthcare issues lost a great, witty and courageous communicator.

Another blow, in fact about a week earlier, was the death of Thurstan Brewin. He was a consultant oncologist and

a past chairman and past secretary of HealthWatch. About a year or so ago my wife and I were discussing whether we knew anyone genuinely wise among our wide circle of friends and acquaintances. Our conclusion was that the prime candidate for that compliment was Thurstan. He was another great communicator, writing wise, well-informed and intensely humane articles in the medical press, ranging from the Lancet to our humble newsletter. We published his most recent article posthumously.

Now for some good news. Caroline Richmond is back! Caroline was one of the founders of HealthWatch when it was known as "The Campaign against Health Fraud." Caroline served as secretary and as editor of the newsletter and I am delighted to welcome her back onto the committee. We need her energy and imagination, her healthy scepticism and her wide ranging knowledge of the world of healthcare.

We are always looking for ways to increase HealthWatch's effectiveness. Earlier this year John Hanford, our treasurer, and I had a meeting with Nick Ross to discuss our future strategy. One of the fruits of that meeting was Nick's suggestion that we should help raise our profile by adopting a number of distinguished patrons. They do not come much more distinguished than our first three patrons, Professor Susan Greenfield (now Baroness Greenfield) who is one of the country's most distinguished scientists; Professor Tom Kirkwood, Professor of Medicine in the Department of Gerontology at Newcastle University, and Lord Walton of Detchant who has held many leading positions including presidency of the GMC. He was the chairman of the Science and Technology Committee of the House of Lords to whom Thurstan Brewin and John Garrow made HealthWatch's submissions last year.

In addition, we decided to offer life membership of HealthWatch to Professor Edzard Ernst who is one of the past recipients of the HealthWatch Award and is Director of the Department of Complementary Medicine at the University of Exeter.

Another innovation is that our literature has a rather snappier slogan. Instead of "Enhancing informed choice through reliable information" it is now "For treatment that works".

In relation to how we run this charity, we have begun the process of setting up working groups to pursue particular projects and we are discussing the feasibility of working with other organisations. Some feedback from the membership and participation from those outside the committee itself would be very much appreciated.

One bit of excitement was when allegations were made about HealthWatch by a Professor Hooper of the University of Sunderland and his co-author Sally Montague in a paper they published on the Web to anticipate the Chief Medical Officer's Report on ME and Chronic Fatigue Syndrome. They alleged that HealthWatch is funded by the drug companies, that its aims are to promote pharmacological interventions and that our membership is only open to those who promote the pharmacological industry. That would rule out myself and most of the committee for a start!

Naturally, the named members were upset at these unfounded allegations. Dr Charles Shepherd in particular contacted Professor Hooper and tried to get the record corrected. Whatever the merits of our position, I believe the committee and membership would agree that there are better uses for our resources than embarking on Court proceedings so, having made our protest to the authors and to the Vice Chancellor of the University, I believe it would be prudent to let matters rest. [but see the [HealthWatch response](#) to these allegations]

I should briefly mention our ongoing activities. The HealthWatch Newsletter continues to be published four times a year. Members of the HealthWatch committee have written to the press and appeared on radio and television programmes doing their best to set the record straight about misleading claims for health products and treatments. Members of the committee have written to numerous people or organisations on our behalf. For instance John Garrow corresponded with the publishers of Dr Foster's Hospital Guide to ask them how effectively they monitored and corrected their data.

One of our major roles has been providing journalists and others with accurate information about health topics. In the past, the telephone helpline was our principal method of disseminating information but to some extent the Website maintained by David Bender is taking its place. It has been receiving a regular and increasing number of hits.

We have two major projects in the planning stage. We are hoping to organise a one day conference on the theme "Flattering to Deceive." The aim is to help doctors, pharmacists, nurses and journalists assess the validity of claims being made for medical treatments, including both conventional and complementary therapy. The second, a student's prize competition, would test the critical faculties of medical students, student nurses and trainees for alternative therapies by asking them to assess the validity of a number of hypothetical clinical trials

We have to conserve our own reserves to cover the cost of producing the Newsletter and the Website so we seek outside funding for such projects. As we report on the front page, John Garrow has been able to secure a [grant of £10,000 for the student prize](#); Michael Allen is currently pursuing finance for the conference. I hope I shall have even more positive news to report next year.

We do look forward to the day we can secure regular funding to put HealthWatch on a really sound financial footing. Meanwhile, I must once more thank all the officers and members of the HealthWatch committee for all

their efforts in keeping this small but worthwhile organisation going so effectively on a shoestring.

Malcolm Brahams

[Top of page](#)

Bioterrorism—separating fact from fiction

HealthWatch committee member and medical journalist Caroline Richmond was at the above-titled Royal College of Physicians briefing held at the end of October at the height of the anthrax postal scare. The audience was composed of public health doctors and medical correspondents yet, it seems, went quietly unreported in the newspapers. Wonder why? Read on...virtually an exclusive for HealthWatch readers, and straight from the mouths of four eminent physicians, under the supervision of Sir George Alberti, President of the College.

There are a number of diseases that terrorists could use against us, but probably won't. This is because germ—and chemical—weapons aren't very effective. A list of previous attempts at bioterrorism showed that most of them were damp squibs. Even the worst—the sarin bomb in the Tokyo subway—killed only 12 people. When I say 'only' this is not to under-rate the awfulness of the act, but to point out that in terrorist terms this is not a lot of deaths.

And the Tokyo subway in the rush hour is, I am told, congested and tight-packed to a degree unknown outside Japan. In the relatively leisurely stations of the London Underground in the rush hour, it wouldn't have managed a fraction as many. And attempts to use chemical or biological agents in previous wars didn't add up to much. There have been eight victim deaths from bioterrorism since 1945, but many more deaths of handlers. This is because germs are difficult to handle safely and can't be delivered in quantity.

Acts of war are intended not only to cause mass deaths, but also to cause widespread hysteria and to demoralise the targeted population. However they usually succeed in having the opposite effect. When the Germans bombed us in World War II they expected to generate mass panic and hysteria. But no: we cleared up the mess, cracked an awful lot of jokes about Hitler's shortcomings, and after that it was business as usual. And then we dropped bombs on them and wondered why they didn't dissolve in mass panic, and so on. This raising of public resilience has happened in the US—recent visitors there have commented on the new feeling of community and togetherness.

There are a number of bacteria that could be used by terrorists but all of them have their shortcomings. Botulinum toxin, which is extremely deadly, was stockpiled in the gulf war but isn't very useful as a weapon as it is killed by chlorine in drinking water. It is worth remembering this when next you wrinkle up your nose and pucker your mouth at the smell and taste of the stuff that comes out of the tap. Plague, which killed thousands of people in the Middle Ages, isn't much of a threat now that we live in properly constructed houses and don't share our homes with rats, as people did 500 years ago. In the last war, the Germans thought of dropping plague-infested rats on us, but never got round to it. This might well have been because they would have been too difficult to handle. Smallpox, which we all took to be a normal risk of life until relatively recently, has limitations as a weapon. It can't be sent through the post, and you can only catch it from someone who's got it. There are stocks of vaccine, and if we run out of vaccines we can always do what Edward Jenner did in 1770, and inoculate people with serum from the blisters of milkmaids affected with cowpox.

Which leads us to anthrax. At the time we went to press, five Americans had died from anthrax in the USA since September 11th, whereas a significant though unknown number of people die of it each year in the Third World. The skin version is like a nasty insect bite, and gets better on its own, without assistance. The respiratory version is nastier, but still treatable. Cipro, which is ciprofloxacin, will cure respiratory anthrax unless it is started far too late in the course of the illness, in which case the patient dies of septic shock. This is because it releases three very nasty toxins. Respiratory anthrax has a long incubation time, so prophylactic treatment should be given for 60 days or until the person at risk has been vaccinated. And, as a bonus, cipro is equally good against plague. How do we know? It works on the same bacteria in animals.

Anthrax used to be endemic in Britain: the last fatality was in 1978. Compare this with the reality that, world-wide, TB, malaria and HIV each kill an estimated two million people every year.

Anthrax is mainly a psychological weapon, and the panic effects have largely worn off in America. It is worth remembering the panic that Aids engendered when it was first recognised. Prison officers wouldn't tolerate Aids patients in prison, and undertakers' staff wouldn't deal with our dead bodies even when they were sealed in body bags. Roll the tape forward ten years, and you got an obligatory hug from Princess Di if you were HIV positive. Much of people's reactions is reflection of their state of mind. This brings us to the fact that the other thing about anthrax is that it's not contagious, so you can't catch it from someone who's got it.

Another reason for not panicking is because Britain's network of public health doctors is among the world's best. The two main dangers to the public at large are not anthrax, TB or botulism, but hoaxes, because the sight of the decontamination team is enough to provoke panic and alarm in just about anyone. The other danger is that a maverick scientist will cash in public concern. There is someone who comes to mind even as I write. This phenomenon, known in cynical circles as Mad Scientist Disease, is virtually inevitable. The press will take him

up—though it's not always a him—as being the only scientist who is not dumbed down by the medical establishment, Chief Medical Officer, Royal Colleges, etc.

Otherwise, and unless there is a moral panic, you can relax.

Caroline Richmond

For all those whose interest is stirred by this article there are two new sources of information. The US Federal Trade Commission's consumer education site, Offers to treat biological threats: what you need to know was set up after the FTC's recent e-mail campaign which targeted promoters of bogus bioterrorism "protection" devices, such as air filters and gas masks, with threats of fines if they could not supply evidence of efficacy. The site is on www.ftc.gov/bcp/online/pubs/alerts/bioalrt.htm. Epidemiologist Ralph Frerichs of the UCLA School of Public Health in Los Angeles, USA has launched his own site, Disease Detectives: American Anthrax Outbreak of 2001, with clinical and epidemiological details on the anthrax field investigation. The site, aimed at public health professionals, students and the public, is on www.ph.ucla.edu/epi/bioter/detect/antdetect_intro.html

See also the letter from Gus Plaut in [Newsletter no 45](#)

[Top of page](#)

A tragic death from "untreated" breast cancer

Jan Willem Nienhuys reports from the Netherlands on the untimely death in August of a famous actress who, it is reported, rejected orthodox medical treatment and instead gambled her chances of recovery on a range of alternative treatments...and lost

On Monday, August 20th at 2am, the Dutch actress Sylvia Millecam died, aged 45, of breast cancer in the Radboud Hospital, Nijmegen's University Clinic. She had been a well known, exuberant and very attractive media personality regularly denouncing obstreperous officials and unreliable businesses in a popular consumer programme along the lines of the UK show 'That's Life'. On the radio she could be heard challenging so-called "quacks" every week, but she also presented a youth program with a mix of science and amusement and a show with Down's Syndrome children. There was great surprise when the Dutch public learned that she had belonged to the one or two per cent of women with breast cancer that reject regular treatment with its 80 or 90 per cent chance of survival.

Millecam had relied entirely on alternative treatment. She had felt a lump in her breast in September 1999, and the official diagnosis of breast cancer, backed up by a second opinion, dated from May 2000. She refused treatment, her fiancé said, because she didn't accept the chemotherapy. She had distrusted regular cancer therapy ever since her father had been falsely diagnosed with lung cancer. He died—in her opinion—ultimately of the consequences of wrong treatment (he died six years later of a brain infarction).

In the fall of 2000 Millecam went to a private clinic in Switzerland which she seems to have located by searching the Internet. There she was reportedly treated with a machine that is said to produce magnetic pulses which were supposed to result in cold fission of the potassium in the body into sodium and oxygen, thereby liberating healthy oxygen and energy. (More conventional physics says that such a fission process requires so much energy that it happens only in the core of an exploding supernova, at temperatures of a few thousand million degrees and densities of millions of tons per cubic centimetre).

Millecam went to see doctors in a homoeopathic clinic in Amsterdam, where she was apparently given ozone therapy and homoeopathic preparations in, paradoxically, large quantities. She went to another alternative practitioner who, it has been alleged, has attempted to treat cancer with capsules of salt, the logic being that this is a powerful medicine which "belongs" to the body because the immune system doesn't attack it.

She also seems to have consulted a physician who in the past is reported to have questioned diagnoses of cancer, believing that the patients merely suffer from the ravages of a biomorphic bacterium.

Then, or concurrently, Millecam consulted a medium, who somehow confirmed her view that she did not have cancer. It was at about this time Millecam started to shun everybody who intimated that her problem wasn't a bacterial infection.

In interviews on Dutch television the medium has since been heard to maintain that she was right, and that Millecam has confirmed this from the Beyond.

Millecam had planned her wedding for July 2001. When the time neared she felt too weak, but she had promised the editor of a gossip weekly that she would soon be fit enough to grant an interview.

She probably consulted more healers than the ones mentioned here, and in which order she visited whom is also not clear, but the latter months of her life she stayed at the home of a trusted family doctor who operates a clinic where he performs colon-hydrotherapy (i.e. enemas), a sound therapy in which voice analysis is followed by permeating the body with harmonious and complementary frequencies, homoeopathy, acupuncture and Voll's

electroacupuncture.

Ultimately the patient was so sick that she couldn't stand up because of oedema in her legs, she couldn't sit because then her breasts hurt so much, she couldn't lie down because then she couldn't breathe, she couldn't sleep, and she could only swallow liquids.

Friday August 17 she was brought to the Radboud, where she was diagnosed (again) with breast cancer, and less than three weeks to live. It turned out to be less than three days. Altogether these treatments cost her something in the order of £100,000, of which a sizeable amount went to the Swiss clinic. All it did was earn her a horrible, untimely and unexpected death, and a posthumous reputation of fatal stupidity.

Jan Willem Nienhuys
Board member of the Dutch organisation "Skepsis"
retired teacher of mathematics in Eindhoven University of Technology

See also the letter from Iain Calmers in [Newsletter no 45](#)

[Top of page](#)

WHAT ARE PATIENTS FOR?



Claire Rayner, who honored us by accepting the 2001 HealthWatch Award at the 1st November AGM, has picked up a few ideas in some fifty plus years of working in and around the NHS. It occurs to her that a question rarely asked is 'What are patients for?' In her presentation she entertained those present with her own answers to this question.

From whose point of view are we to look for the answer? That of the patient? Or that of the doctor? Or, since we have a highly politicised NHS, that of the politician? Clearly, it will have to be from all three. And I shall begin with that of the patient.

The most pressing is of course:

Curing Above all else we seek relief from our symptoms and the banishment of fear of future symptoms. There are some unfortunate people, however, who have a desperate need for the attention of doctors and who are happiest when they have a few (preferably not too disagreeable) symptoms of sufficient medical interest to keep doctors hovering at their sides. These are the ones who want most of all:

Looking after while being cured Regression into a state of juvenile dependency is a common part of being ill, be it physically or mentally. So, we need to have someone who makes us feel safe and cared for well within reach all through the illness stage and afterwards too if we can get it. Meeting your doctor in the supermarket and having him say, "And how's the old trouble then?" makes you feel important and valued, unless of course the old trouble is something mildly embarrassing like an addiction to masturbating while wearing scarlet panties.

One reason for wanting the doctor there during illness is to be:

Listened to At a time of stress human beings have a deep need to talk about it, to anyone and indeed everyone who will listen, as anyone who has ever worked in an A & E department knows well. But it is not only after trauma that this need exists. Those who live in constant pain or discomfort need others to know how much they suffer. They may in consequence be shunned by their nearest and dearest, which means that finding someone else to listen to necessary outpourings of distress becomes very important indeed.

A caveat must be entered for some patients: the inarticulate, those who are overawed by doctors and those who simply don't have the language with which to express their needs for a listener. They are the patients who reckon their medical attendants are for:

Being psychic about Some patients don't give you vital information about themselves and their condition, but instead look at you trustingly, sure that you will understand anyway and know exactly what they mean when they respond to your question about their pain by telling you it started in the middle of Mary's wedding reception.

And as if listening to patients wasn't enough for a busy practitioner, patients also believe that they are for:

Explaining to How some clinicians must yearn for those fabled days when a doctor could pat a patient's shoulder or head and say; "Don't you worry your head about any of this, we're here to do the worrying and the thinking, you're here to hrrmph...get better." Well, those days are indeed long gone and not a moment too soon from a patient's point of view. We want to know, in every detail, what our symptoms mean, what signs you have observed in examining us and what they mean, what the latest treatment is for our condition, its safety rate, its failure rate and all other available evidence for its efficacy. And even those of us who are totally unable to comprehend such things as risk /benefit ratios (after all many of us buy a lottery ticket at fourteen million to one odds every week) we still want to be told. And told over and over again in order to take it in properly.

For being encouraged Being ill and getting over it does take a certain amount of patient as well as medical

effort. They want—indeed, need—their doctors and other attendants to tell them at frequent intervals how well they are doing, how brave they are being, how hard they are trying, how patient and sensible they are, with always the underlying implication that this patient is and always will be the doctor's all time favourite. There is a particular group which needs this encouragement badly, wanting:

To be cared for, however unlovable As a young nurse the hardest lesson I had to learn was how to show all patients equal concern and interest, even the ones who stank, who coughed and spat revoltingly, who were triply incontinent (triplly inasmuch as they always seemed to produce their most malodorous releases of flatus when I was tending to them) and who had eyes that were full of greenish exudates. I also had to learn how not to retch when they vomited or when they coughed and spat. Only those of us who have had need of this medical/nursing ability to dissemble can know how important it is. And now, to go from the truly sublime to the very irritating indeed, patients are for:

Requiring signatures on passport applications and similar extremely annoying trivia. There are GPs I have heard of who demand sizeable fees for appending their scribbles to the backs of ghastly passport photos and suchlike and I can't blame them. But I beg you not to blame the patients who make the requests. Attack instead the bureaucracy that demands it.

There is another thing that patients believe that they are for, and it is one that exercises greatly the minds of many of us. We are for:

Escorting through death I, like a great many other patients, would like to be sure that all medical staff at all levels would, when the time comes for the inevitable ending of a life, make every effort to provide supportive, dignity-protecting and genuine care. Sadly, all too often hospital-based medics step back, leaving it to the family to cope with what time a GP has to spare them and, if they are lucky, the care of a specialist nurse. Old people tend to be the most neglected in this way, in my experience. Though I have at this point to express a deep and undying gratitude to a geriatrician who recently treated an elderly relative. He saw him at home at frequent intervals as well as in hospital, and continued to care for him, even though there was no doubt that that his death was inevitable. There is a great deal that can be done for a patient even after a disease process has triumphed and is galloping full tilt for the finish, and he did it. Of course, this geriatrician did what all patients want all of their carers to do at all times because patients are for:

Being kind to There is not the least doubt in my mind that a doctor or other health worker could get away with literally murder, as long as he or she did it with kindness, warmth and an air of sympathy. Dr Shipman had many patients who even after he was found out commented on what a nice kind chap he had always been. And many are the so-called alternative practitioners who offer nonsensical nostras and pseudo-scientific chatter and then pocket comfortable sums and get away with it on account of being "ever so kind". Patients given even the most skimmed a portion of the milk of human kindness will forgive almost anything.

There, then, are the ten things patients think they are for. We must now turn the mirror the other way and look to see what doctors think patients are for.

So, as far as doctors are concerned, patients are for:

Curing The patients' reasons for wanting this are obvious. What are clinicians'?

Well, one has to assume that it was what he or she came into the profession to do. It must come as a shock to those eager students when they are told by their teachers at the start of their careers that cure is a word to be used very sparingly. Speak of giving relief, speak of amelioration, speak of repairs, but be very, very careful about discussing cures—they are few and far between and if you offer one and can't deliver patients will never forgive you. And the next one?

Being grateful Having someone look at you with swimming eyes filled with something akin to worship because you've done a competent job, as you were trained to do, can be embarrassing at one level, but deeply, gloriously satisfying on another.

Nurses get a very large dollop of gratitude if they do their job even half well. I had a letter only last week from a middle aged woman I had nursed when she was a child back in the fifties. I confess to having no memory of her at all but she listed all sorts of things about her memories of me that made my day. Indeed, I think perhaps it's made my year.

Those are the lofty uses for patients, now its time for the mundane. They are for:

Making a living This one is not as high on the list in the UK as it is elsewhere, notably in the USA. I have met a great many US doctors and they have all been, without exception, extremely comfortably off merging into downright rich. Swimming pools to die for. On both sides of the Atlantic, this use of patients moves on to another level when it is time to use them for:

Building a career A modest living can be made in the UK with the most basic of medical qualifications and top-up education of the sort now demanded, but if you really want to Get On, papers are required. Published Papers.

Often, of course, patients are for:

Providing teaching material Medicine is an art and craft as much as a science, because the objects of the practice of medicine are sentient human beings; all of them different, all with assortments of symptoms instead of nice tidy syndromes, all with their own special complications of gender, age, race, social class, degree of poverty and all the other imponderables that go to make us all so fascinating. The only way a doctor or a nurse or a physio or any other therapist can learn their job is by putting their hands on people and using their own eyes to look at them, their own ears to hear them and, a sometimes neglected but in my experience very important aid, their own noses to smell them. This use of the honest-to-goodness ailing person leads on to another. Patients are for:

Being research animals A rather odd looking doctor used to come sometimes to the men's medical ward at the Royal Northern Hospital where I trained as a nurse in the fifties and ponder over those of our patients who had carcinomatosis and were there waiting to die, and to some of them he would administer some muddy brown liquid from a bottle he carried in his hip pocket.

He had this crazy notion, sister told us with a sniff, that it might be possible to treat cancer with drugs. We thought he was barmy. I stopped him one day and asked him what he was doing.

"Experimenting on 'em." he said, with commendable directness. "Is that right when they're so ill?" I asked. He clearly thought I was the one who was barmy. "What possible use are they to anyone else but me in that state?" he said and left me gaping. Next day I was transferred to theatres, I remember, and glad to get there.

I do not suggest that researchers are quite so cavalier these days. But I do know that medicine and its practitioners still need to use human beings for research as they set about their vital business of pushing forward the frontiers of medicine. One problem with research is of course that it is even more likely, if badly organised, than other forms of medical practice to lead to one of the most unpleasant uses of patients:

For being sued by On the whole, British patients are not particularly litigious, usually wanting simply an explanation, an assurance it won't happen again to any other patient and an apology when things go wrong. Evidence shows, however, that some of us are looking more sharply across the Atlantic than usual, especially now the legal concept of fighting a case on a "no-win, no-fee" basis has arrived here.

In case you feel I am being too cynical, do let me agree that one of the most important uses of a patient from the point of view of good, caring, well-balanced and well-disposed clinicians is as an:

Object of altruism To this day many people—and I here include patients as well as doctors and all other health workers—feel a deep and genuine drive to take care of others, to minister to their needs to relieve pain and misery of all possible kinds, to do what Florence Nightingale, now slowly toppling off her pedestal, once described as the core of nursing. To comfort always. I have to admit, however, that altruism may come mixed with other motives. One of them may be the need to find a way of:

Escaping from real life Hospitals, surgeries, operating theatres and clinics are intensely exciting and romantic and diverting places when they're not being exhausting, disgusting, dangerous, frightening and sickening, that is. For people who lack the social skills needed to build satisfying personal relationships, being with colleagues and, above all, patients can be very comforting. Patients ask a lot of you, of course, but not as much as a lover or a child of your own might demand. I have to say I have met many nurses and doctors and others during my many years hanging around hospitals who fit into that category all too neatly.

There remains one final use of patients by doctors in particular and it is one that was expressed most neatly by a surgeon I knew well, for whose theatre cases I regularly acted as scrub nurse. He was MacNeill Love and he would tell each new houseman the same thing on his first day.

"Young man, a surgeon's career is in three stages. The first is to get on. The second is to get honour. And the third is to get honest."

I end by offering you, as I promised I would, the Politician's answer to the question "What Are Patients For?" I will list them while making no attempt to qualify them in any way. I rather doubt I need to. You will know the detail perfectly well:

For winning votes

For losing votes

For lying to (about waiting lists, quality control—"of course we don't allow post code prescribing"—and practically everything else)

For appearing to spend money on while doing nothing of the sort

For counting and recounting in order to obfuscate true facts (see "for lying to" above)

For whipping the opposition at all times

For blaming ("you dare to ask doctors for antibiotics, you miss your appointments, you use the Internet!") and being the cause of all NHS problems in general

For sucking up to come election time

Do you honestly believe in miracles?

Matthew Parris, controversial ex-Conservative MP and now journalist and broadcaster, mused on the question of miraculous healing for The Times (1st September 2001). It is reproduced below with his kind permission

First, the story. Then a question for a group of people all of whom I respect, many of whom I look up to, and some of whom are friends. Monika Besra is an illiterate tribal woman from one of the most downtrodden communities in West Bengal. A mother of five from the town of Raigunj, she does not even know how old she is. In May 1998 she was in great pain from a huge growth in her uterus.

Leaving family behind she limped into a shelter for the destitute run by Mother Teresa's order, the Missionaries of Charity, in the town of Patiram. She stayed. "For two months I had severe pain, terrible pain, and I was crying. I could lie only on the left side and I couldn't stand straight," she said. Medicine did not help. Trips to the hospital did not help. She prayed to Mother Teresa's picture near her bed.

On September, 5, 1998—the first anniversary of Mother Teresa's death—two nuns took an oval, silver medallion that had been placed on Mother Teresa's body after her death and tied it to Mrs Besra's stomach. She fell asleep while the sisters prayed and wept, holding her stomach. When she woke the tumour had gone, she said. Within three days she was cured. Later, diocesan investigators interviewed Mrs Besra and talked to doctors who, it is said, confirmed that the tumour had disappeared.

Mrs Besra's story was this week being considered by a tribunal of Vatican theologians whose task is to help to decide whether the late Mother Teresa should be made a saint. Pope John Paul II has put the former Albanian nun on a "fast track" to canonisation.

A saint must first be beatified. This requires proof of one miracle. Another will be needed for canonisation. Apparently miracles performed after the death of the person who is their claimed agent count especially heavily in favour of the candidate. I have the impression that one reason for this is that although Roman Catholics accept that a person may be regarded by other human beings as a saint before that status has been officially pronounced, to be a "saint in Heaven" there must be confirmation from Heaven.

The opinion of the Archbishop of Calcutta, Henry D'Souza, is that inquiries already made on Teresa's behalf "have met the essential requisites of being organic, immediate, permanent and intercessory in nature". Father Brian Kolodiejchuk, a Canadian priest appointed "chief postulator" of Teresa's cause, says in his extensive report that he is "overwhelmed" by her sanctity.

Nine theologians from the Congregation for the Causes of Saints and 30 cardinals will lead further consideration. If, as expected, beatification quickly follows, a second claimed miracle must then be selected and proved before Teresa can be called a saint in Heaven.

There are already suggestions. Sister Rita Mascarenhas, a Catholic nurse who was paralysed from the waist down, says that two days after Teresa's death a friend praying at the body touched it with a piece of cloth. Mascarenhas pinned the fabric near the source of her pain. She then dreamt of Teresa and heard a voice telling her to get up and walk, which she did. A Palestinian girl suffering from cancer says she was cured after Teresa appeared in her dreams and said: "Child, you are cured."

Let us for the present accept everyone's good faith and that such evidence as is available does point to astonishing events. We must accept, too, that this bid for canonisation looks certain to succeed. When it does, that decision will have turned on one key step in the argument. The Pope must pronounce as answered this final question: taking as read an apparently inexplicable event, is the explanation God? As the rationalist philosopher David Hume pointed out more than two centuries ago, when the impossible is claimed we may always conclude that somebody's senses must have deceived them. A miracle "proves" nothing because the believing of it is itself a non-rational act of faith. Only if the Church is prepared to take that leap, prefer the account to the impossibility of the account, and make God the explanation do we have, in the theological sense, a miracle.

Let us be clear what is meant here by "God as an explanation". This is not some Anglican mumble about deity being everywhere and behind everything and therefore part of all acts of love and healing. Nor is it the mystics' view that there exists something indefinable and more mysterious than the knowable, to which the unexplained may alert us. That is not what Catholic priests all over the world, and especially in Asia, Africa and South America, will be telling their flocks. They will be preaching that this healing had a perfectly explicable and definable cause: the tumour-dispelling power invested in an oval piece of silver on account of its temporary adjacency to the deceased body of a woman whom God had chosen as one of his saints in Heaven.

There are thus three elements to this miracle: the spiritual potency of a material object; the potency of a corpse it had touched; and the agency of a divine will in the production, by this means, of a particular outcome.

And so I must turn to some people I respect. They are people whose judgments in public affairs you and I are accustomed to take very seriously. I must ask them this: do you believe that the application to a woman's body of a medallion which had touched the corpse of a woman who was to be made a saint, caused a huge, fatal tumour to disappear within three days? Do you honestly and straightforwardly believe it? Do you believe it Chris Patten, whose guidance on less important questions I always yearn to accept? Do you believe it Iain Duncan Smith, recommending as you do to the party you lead a range of other beliefs? Do you believe it Hugo Young, whose personal judgment commands such authority among political historians and commentators? Do you believe it General Sir Charles Guthrie, upon whose estimates of other likelihoods the lives of so many fighting men could depend? Do you believe it Charles Moore, who helped to bring down a Conservative Government and whose Telegraph editorials are gospel in many households? Do you believe it William Rees-Mogg, whose other assessments of the world in which this claimed miracle is said to have happened are so clear and bold? Do you believe it Paul Johnson, whose creative writing I so much admire? Do you believe it Charles Kennedy, whose Catholicism pleases and attracts many potential voters? Do you believe it Bill Cash, whose confident reckoning on European probabilities helped to shape an epoch in your party? Do you believe it Cherie Blair, whose mind must be an insistent force behind the scenes of government? Do you, all of you, really think that from Heaven an Albanian nun cured an Indian peasant of a terminal medical condition? Do you think a piece of metal could carry such power? That touching a cadaver's skin made the difference? Because I don't. I think the whole idea is plumb crazy. I cannot see how any intelligent person with a good knowledge of the world, a careful judgment and a proper distrust of superstition, could believe such things. I am dumbfounded, vexed, bewildered—gobsmacked—that some apparently sane people still do.

How often do we confront them? Who asks them these questions? We move among and socialise with people with an unbelievably weird credo, and never discuss it. Glenn Hoddle was hounded out of a job to which his personal faith was irrelevant because he believed we are reincarnated according to our desserts. Yet European Commissioners, newspaper editors and respected columnists, party leaders and prime ministers' wives believe—or apparently do—that from a Heaven where souls have gone according to their desserts a deceased nun is being promoted among us by God through the strange agency of a piece of metal that touched her corpse. Do these men and women accept in all its simplicity the claim that priests will soon be making to simple, desperate people all over the world? Or do they acknowledge it as a necessary invention, promulgated knowingly in the higher cause of winning converts? And, if so, what other lies have been promoted in the same cause; and which of them have we believed?

Matthew Parris

[Top of page](#)

Letter to the editor

David Bender: fasted if not detoxed?

Richard Pitcairn-Knowles, retired osteopath of Sevenoaks in Kent and Healthwatch member, writes:

Much as I agree with David Bender (front page of HealthWatch Newsletter [issue 43](#)) that claims for "detox" are more than overstretched, I do not have his faith in his liver and his kidneys which he will agree will not take excessive abuse and overload, e.g. with alcohol. May I comment on his view with an unscientific analogy?

The liver is a resilient and powerful organ as are the kidneys; similarly our water companies' sewerage systems are an ancient and efficient idea, usually functioning well, but we have heard much about sewage flooding streets and homes when local authorities allow too many new housing estates to be built; nitrates, oestrogen, etc., etc., are now damaging the oceans, large enough, one would have thought, to dilute and destroy efficiently anything thrown at them! Usually efficient systems cannot take the abuse of overloading.

David Bender says that "...The body is perfectly adept at ridding itself of unwanted toxins in food...it is broken down in the liver and excreted". But if the body is overloaded with, say, alcohol, caffeine and many medicinal chemicals, it cannot cope and will fail as surely as the sewerage system.

It seems for most of us that if we do not take a holiday our work efficiency, if nothing else, suffers; we usually come back from holiday rested/stimulated physically and mentally and more efficient.

Much as I do not like the term "detox", a holiday from ingesting any chemical, be it food, drink or medication (unless essential), a fast by any other name, gives the liver and kidneys a rest and it is a proven fact that the liver recovers remarkably from abuse if the abuse ceases.

So please, David, do not throw out the bathwater and lose the fasting baby, however small and weak the baby appears, it may come back to argue with you when adult if you give it its chance now!

Yours faithfully
Richard Pitcairn-Knowles

Richard Pitcairn-Knowles recently published a photographic history book about pioneer European photo-journalist

Andrew Pitcairn-Knowles who published the first sports picture magazine, "Sport im Bild" in Berlin in 1895 and travelled Europe as a photo-journalist in search of stories which he illustrated with his own photographs, many in the book. The Edwardian Eye of Andrew Pitcairn-Knowles 1871–1956 includes over 100 photographs and is published by The Book Guild at £25 (hard back). ISBN 1 85776 4277.

[Top of page](#)

PILLS AND POTIONS BY POST

HealthWatch committee member David Bender has been enjoying himself leafing through catalogues of pills, potions and assorted wondrous remedies available by post that have landed on his doormat recently. He thinks you can save quite a lot of money by ignoring them

You can now buy just about anything by mail order, so it's not surprising that "health" products of various kinds are freely available through the post. We'll put the word into inverted commas because we use the term loosely—some may have more to do with vanity than health, and some might, despite claims, do nothing for your health whatsoever.

Tanning tablets

These claim to give you a film star tan to be proud of; you can stay tanned all year round. We are told that suntans can be hard work, expensive and sometimes difficult to acquire. I fail to see how it is hard work to lie on a tropical beach, although it is expensive. We are told they are not a dye. They contain L-tyrosine, "an important precursor of melanin, the skin's own natural pigment, plus silica, and other vitamins and minerals". Well, yes, the amino acid tyrosine is the precursor for melanin synthesis—and it is a ubiquitous component of all dietary proteins, so you are not going to be short of tyrosine. Moreover, melanin is formed when the skin is exposed to sunlight (or UV light in a tanning parlour). Taking more tyrosine will not lead to the formation of more melanin.

Aerobic oxygen

Another product to replenish the oxygen we are apparently lacking. I cannot think what anaerobic oxygen might be. According to the label, this product consists of stabilized molecules of oxygen in a sodium chloride compound consisting of oxides of chloride (sic), sodium and carbonate; 30 drops are mixed in 8 oz of fluid and drunk three times a day. From the label this might appear to be little more than salt water that has been exposed to the air, but according to the manufacturer it does provide more oxygen than would dissolve in water. This suggests that the "oxide of chloride" is in fact sodium hypochlorite, and what we are being offered is a drink of diluted bleach (perhaps equivalent to drinking swimming pool water) as a source of (a very small amount of) oxygen.

To put these sources of oxygen into context, an average person consumes some 500 litres of oxygen each day, so it is difficult to see how the recommended amount of either product could provide a significant amount of additional oxygen.

Spirulina—nature's richest whole-food source of vitamin B12

Spirulina is a blue-green freshwater alga that has been eaten for centuries in Mexico and around Lake Chad in Africa. We are told that it is two to six times richer than its nearest rival, raw beef liver. This is somewhat disingenuous, since we are being offered tablets of dried spirulina, which are being compared with fresh liver, which is about 70% water.

More importantly, it is misleading and wrong, but legally correct, to claim that spirulina provides vitamin B12. The problem is that vitamin B12 is a complex molecule, with 15 different side-chains attached to the central ring structure, and all are essential for its function as a vitamin for human beings. There are a great many related compounds that do not have vitamin activity, and indeed some may have anti-vitamin activity. However, micro-organisms can use many of these compounds that do not have vitamin activity, and the legally required method of measuring vitamin B12 in foods is by a microbial growth assay. This means that compounds with and without vitamin activity are measured as "legal" vitamin B12.

There has been a recent report that samples of spirulina collected from various lakes do indeed contain some true vitamin B12 as well as the inactive compounds; the amount was very variable, depending on the source of the spirulina. The evidence suggests that the true vitamin B12 is coming from faecal contamination of the lake water—hardly a selling point for a health-food supplement.

Norwegian seaweed extract for more oxygen in the body

You may not be aware of this but, we are told, the oxygen levels that circulate in an aeroplane while flying long distances are much lower than you would be used to while on the ground. I would quarrel with much lower, but, yes, there is less oxygen in an aeroplane pressurised to an altitude of 10,000 ft than there is at sea level—and the problem is the same on a short or long flight. We are told that this preparation of Norwegian seaweed (a liquid that you swallow) provides oxygen for your blood within 30–60 seconds, and the benefits last for two to three hours. When cabin crew were given this product their blood levels of oxygen "shot up 10 to 15 points (we

are not told what points mean) and the negative effects of flying disappeared." We are told that this product is naturally extracted, so "if you are an athlete, undertake heavy physical labour or are in any situation where additional oxygen would assist your performance or breathing capacity, this is what you need."

Improve your sexual performance electromagnetically

"Put this magnet into your pocket, where the magnetrode then transmits its therapeutic magnetic field throughout the genital area. The aim is to encourage blood flow, oxygen supply, nutrition and production of sex hormones." The Shorter Oxford English Dictionary does not have an entry for magnetrode, and neither do any of the other reference works I have to hand, so I cannot be sure what they are selling me, although for £9.95 (reduced from £14.95) it sounds like a bargain. We are told it is 100% safe, with no known side effects (but not to use it if you have a pacemaker fitted). I am sure it is safe—and I am sure it does not work. To misquote Mae West "Is that a magnet in your pocket, or are you just pleased to see me?"

David Bender
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[Top of page](#)

Faith or reason?

John Garrow reviews:

**The Natural Health Bible by M Stewart and A Stewart
published by Vermillion Press, London, 2001. pp 528.
ISBN 0 09 185614 0. Price £12.99 (paperback)**

...and

**The Desktop Guide to Complementary and Alternative Medicine (ed. E Ernst)
published by Mosby, Edinburgh, 2001. pp 444.
ISBN 0 7234 3207 4. Price £24.95 (including CD)**

These two books make a fascinating comparison. The sub-title to the Stewarts' book is "An A-Z guide to drug-free health". The introduction to this "bible" begins, "For seventeen years we have been banging the drum about the wealth of scientifically proven benefits of non-drug medicine..." and goes on to lament the general ignorance of doctors concerning the value of non-drug medicine, which leads them misguidedly to resort to "a predominance of drug-based medicine".

Having read this introduction I expected to be introduced to the wealth of scientifically proven benefits available to patients without the use of drugs, but this expectation was not fulfilled. Appendix III runs to 16 pages, and is headed "References". These references refer to Part Two of the book in which about 100 health problems are listed alphabetically, from "Abdominal wind and bloating" to "Varicose veins", but the references cited do not provide proof of the benefits from the suggested non-drug therapies. For example, for acne, ageing, alcoholism, back pain—and another 31 problems—the Appendix tersely commends "Standard references", but does not indicate what "standard references", or what treatments or benefits these references endorse.

The layout of the entry for each of the health problems is admirably clear. First the nature of the problem is described, what causes it, what your doctor can do, what the patient can do, and what complementary therapies are appropriate. For example, it is stated that headache is usually due to contraction of muscles of the scalp, neck and face or shoulders, or perhaps (cranial osteopaths say) stress to the cranial fascia. No references are given to justify this view of the aetiology of headache. Rarely it is due to a serious underlying medical condition such as leakage from blood vessels, or very rarely a brain tumour.

Next, what can the doctor do? Examine you, find a cause or else reassure you. Analgesic drugs, sedatives or tranquillisers may be useful in short courses. (This is a surprising concession given the anti-drug stance of the authors). If necessary your doctor may refer you to a neurologist. There is then a list of 14 bullet points indicating the action the patient can take, including advice on a nutritious diet, avoiding excessive tea, coffee, alcohol or potential allergens, not missing meals, avoiding stress, taking exercise, massage, aromatherapy, vitamin and mineral supplements, and chewing ginger. Again, there is total silence concerning the evidence that these measures bring any benefit. Concerning complementary therapy, the authors state "Cranial osteopathy is the first choice of treatment...herbal medicine, homoeopathy and acupuncture all have something to offer." The references for this section in Appendix III, in addition to the usual "Standard references", cite only one review published in the New England Medical Journal in 1980 which does not, by my reading, offer any scientific evidence for any of the complementary treatments advocated above.

Although this book is weak on evidence, it is rich in anecdote. The text is seasoned with passages, usually in italic type, that tell Judith's story, Martine's story, Bernice's story, etc. These tell how Judith, Martine, Bernice,

and many others like them, were healed by following the advice of the WNAS (the Women's Nutritional Advisory Service, established in 1987 by Maryon Stewart). If the advice of the WNAS has ever failed to help anyone, it is not reported here.

The "desktop Guide", edited by Prof E Ernst, has quite a different structure. Ernst and his co-workers gather all the available evidence from controlled clinical trials using complementary or alternative medical (CAM) treatments. The evidence is fully referenced and up-to-date. Based on that evidence they reach reasoned conclusions. This different approach leads to different conclusions from those reached by the Stewarts.

For example the "guide" devotes six pages to the treatment of headache. As with each problem the condition is defined, and an assessment is given of the use of CAM for its treatment (in one survey 32% of Americans with headache had used CAM in that year). Then, for each condition, the evidence of treatments' efficacy is set out in alphabetical order: acupuncture, autogenic training, biofeedback, electrotherapy, herbal medicine, homoeopathy, hypnotherapy, relaxation, spinal manipulation and "other therapies".

There is then a summary table showing the weight of evidence, the direction of evidence, and concerns about the safety of each CAM therapy reviewed. The final conclusion is that "The evidence is not convincing that any particular CAM therapy is more effective than placebo in preventing tension headaches." Finally there is a list of 17 references to controlled trials of CAM treatment for headache, all of which are more recent than the single 1980 review cited in the "bible".

Although the conclusion of the "guide" is that there are few conditions for which there is convincing evidence for the efficacy of CAM, the authors show no systematic anti-CAM bias. For example they list acupuncture for nausea, biofeedback for constipation, kava for anxiety, relaxation for anxiety and saw palmetto for benign prostatic hypertrophy as CAM treatments which have been shown to be effective by systematic reviews. Indeed, even the absence of any credible mechanism of action does not prevent the authors from commending a CAM treatment if that is the way the evidence points. For example, following the main conclusion (cited above) that there is no convincing evidence that CAM stops tension headaches, they list therapies which are deemed safe, and for which there is suggestive evidence of benefit. As they note, "in the absence of genuinely safe and effective conventional treatment", these are CAM treatments which might be tried.

Another fundamental difference between the "bible" and the "guide" concerns the presentation of information about complementary methods for treatment and diagnosis. The "bible" makes no critical analysis of methods for diagnosis, and devotes 7 pages to describing "The Strengths of Complementary Therapies", namely acupuncture, acupressure, cranial osteopathy, herbal medicine, homoeopathy, healing and self-healing. This section is suitably deferential to the founding fathers of these therapies and their philosophies, and makes no mention of evidence of efficacy, or risk of harm, from their application.

The "guide" devotes 6 pages to diagnostic methods: bioresonance, chiropractic, iridology, kinesiology, kirlian photography, laboratory tests, pulse tests, reflexology charts, tongue diagnosis and vega-test. The evidence indicates that "some, but not all, chiropractic diagnostic methods are valid", but the others are described as "invalid" or at best "questionable". This is an important observation, because if the method used to diagnose disease is invalid, then the choice of treatment, and the assessment of response to treatment, is likely to be equally unsound. The "guide" is far more comprehensive than the "bible" in examining the therapies (n=20), and the herbal and non-herbal medicines (n=44) used in CAM. The book comes with a CD by which this very valuable database can be rapidly searched.

Healthcare practitioners, or lay persons who wish to make informed choices about the treatment they are offered, certainly need help in assessing the merits or dangers of CAM. Ernst's "guide" is a wonderful work of scholarship that impartially presents the available (but so far inadequate) evidence on which such choices can be made with the exercise of reason. The Stewart's "bible" falls far short of the claim that it "is the first scientifically based book for both men and women that looks at treating health problems by nutritional rather than chemical means." If we have no sound evidence on which to base our choices we must rely on faith, but if there is evidence it is stupid to disregard it. Ernst has done us a great service by making the evidence available to those who seek it.

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[Top of page](#)

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