

Newsletter no 45: April 2002

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What is screening hiding?

Last month the IARC (International Agency for research on Cancer) experts appeared to give mammography the all-clear. Lancet Oncology, on the other hand, called for a thorough reappraisal of breast-cancer screening¹, with the words, "Only with the implementation of a strictly controlled high quality trial will the controversy over the true value of breast cancer screening be resolved." John Garrow would agree with the latter, after a lengthy search for evidence of benefits leaves him ever more sceptical.

When the word "screening" is used in a healthcare context, what image springs to your mind? Is it the sieve used to separate the rare granules of gold from the worthless gravel from the bed of a gold-bearing stream —analogous to finding a small number of undiagnosed cancers in an apparently healthy population? Or do you picture the makeshift shelter erected by police around the site of a gruesome incident, thus screening it from the inquisitive eyes of the public?

Health ministers take great pride in cancer screening programmes: it is obvious (they say) that detecting cancers at an early stage must make treatment more effective, and thus save lives. Well, yes, that may be true, but it is certainly not obvious. "Screening should be a matter of informed choice for the informed citizen who—unlike the situation when immunisation controls infectious diseases—does no harm to others should he or she prefer not to join a campaign," wrote Dr Thurstan Brewin, the late HealthWatch stalwart, in his [Position Paper on Screening](#) that was published in HealthWatch Newsletter 22 in July 1996. (This is accessible through our website www.healthwatch-uk.org, or by post from our press officer.) "It is not right to give people an exaggerated view of the benefit to the individual, purely in the hope of improving community statistics," Dr Brewin concluded.

This is the crucial point: what are the benefits to the woman who joins the current cancer screening campaigns to detect breast cancer by mammography, or cervical cancer by smear testing? There is increasing anxiety among health professionals that an exaggerated view of the benefits is being presented both to individuals who are recruited for screening, and also to the public that such campaigns are cost effective. The financial costs to the community are substantial: £52m annually for breast screening and £132m for cervical screening. There are also other costs: performing 1.5m mammograms and 4m cervical smears uses precious resources in equipment and skilled workers that could otherwise be deployed to provide better laboratory resources for the NHS. Screening work may have serious negative effects on the morale of laboratory workers: it requires meticulous technique to keep errors to a minimum, but when inevitably errors occur these workers are vilified in the media.

To justify this burden on the community it is necessary to show substantial benefits to the individual. It is claimed that screening saves lives. Members of HealthWatch will know that the most reliable way to prove this claim is to compare mortality in communities who have been randomly allocated either to screening or no screening. Unfortunately no such controlled trials have been done for cervical screening. Comparisons have been made between women with, or without, breast screening, but there is controversy among experts concerning the effects of screening on breast cancer treatment and mortality. The arguments are too technical to review here: the interested reader should consult the research letter by Olsen and Gøtzsche² and the subsequent correspondence³. In summary, they conclude "there is no evidence of benefit, but evidence of harm," from breast screening, since all-cause mortality is not reduced, and treatment for women who have been screened is more aggressive than for those without screening. It may seem strange that experts cannot agree on the effect of screening on mortality. The problem is to assign correctly the cause of death among women who have been

screened. If a woman has a breast cancer detected, receives radiotherapy, and subsequently dies of cardiovascular disease, in part caused by the radiotherapy, is that case to be included under breast cancer mortality? If the cancer were of a particular type (ductal in situ) would it have killed the woman even if she had received no treatment at all? At the very least, it seems that the well-informed woman giving consent to mammography should be aware that the claim that "screening saves lives" is not universally accepted.

The Department of Health was evidently aware of these misgivings. In November 2001 Lord Hunt, the Minister of Health, held a press conference to launch new leaflets to bring about a new era of trust and honesty between patients and the NHS. "The aim is to provide accurate information on what screening can and cannot achieve, so women can make an informed choice. Clearly, screening is not perfect." Bravo! We were about to send off a HealthWatch membership application form to Lord Hunt, since his aims were so identical with ours, but then we read the literature that carried this "accurate information".

There are two 12-page leaflets Breast screening—the facts (ISBN 0 7521 1970 2) and Cervical screening—the facts (ISBN 0 7521 1969 9) and two 20-page A4 Annual Reviews: Informing choice in breast screening (ISBN 1 871997 49 6) and Informing choice in cervical screening (ISBN 1 871997 54 2). These seem to us to fall far short of the stated aims. The Annual Reviews both carry an article by Dr Joan Austoker entitled "New information leaflet helps informed choice". She explains that when revising the old leaflets the authors "struggled in particular with how to quantify clearly the degree of possible risk of false positives and false negatives," and "are still wrestling with the problem of numbers." There is little success evident from all this struggling, since few risks are described numerically. The claim is made that screening saves lives: 1,250 annually by breast screening and "over 1,000" by cervical screening, but no indication is given of what this represents in reduction of risk. Is it 50%, or 5% reduction? Also, there is no indication that some respectable researchers doubt that there are any lives "saved". It is acknowledged that the screening tests are "not perfect": that for various reasons a cancer may be missed (a false negative), but the reader is left to guess if this applies to one in a hundred, or a thousand, or a million of those screened. The possibility is never mentioned that a woman may have a cancer diagnosed but, after operation, it is found that the abnormal tissue is not malignant (false positive).

Since these documents are supposed to enable the woman to make an informed choice it is amazing that there is no clear statement of the disadvantages to the individual of screening, which are well set out in Dr Brewin's Position Paper of 1996. The main problem is the anxiety caused to the very large number of women (78,843, or 5.3% of those annually screened for breast cancer, and 9.7% of the 4 million smear tests) who are recalled for a repeat test. The vast majority of these women do not have cancer and are perfectly healthy, so this anxiety would not have arisen if they had not entered the screening programme. Of the 9,525 breast cancers detected in 1999/00 the "ductal in situ" category accounted for 21%. So each year there are 2,000 women who now know they have an early cancer that is causing no symptoms, and may never cause symptoms if it is left alone. If they apply for life insurance, or health insurance, or employment, this diagnosis of cancer will be a handicap that they may wish they had avoided.

Dr Austoker writes that presenting risk information "is certainly something we will look at with a much bigger number of women when it is in use." It is not clear what that sentence means, but evidently she is unable or unwilling to express the risk of false positives or false negatives on the experience of a 1.5m breast screened annually, or 4m cervical smears annually. This failure to explain these risks is not compatible with Lord Hunt's commitment to provide "accurate information". A clinician would not escape censure if "informed consent" for an investigation or operation were based on information so incomplete and biased as that contained in these new leaflets.

It seems that there are two, linked, sets of problems with the present cancer screening programme. The first set concerns the lack of information given to women recruited for screening: (a) What are the upper and lower limits of confidence for the estimates of the annual number of lives saved (stated as 1,250 / >1,000 for breast/cervix respectively)? (b) For every thousand women recruited today in a well-run screening programme, what is the probable number of false negatives, or false positives? This information must be available to the Department of Health, but it is not made public, and without it a woman cannot give informed consent to be screened. After prolonged enquiries I was referred to Dr Muir Gray, who is Programmes Director of the National Screening Committee, and who kindly agreed to send me the answer to these questions "very soon" when I met him on 31st January. At the time of writing (24th February) I still do not have these answers. I do not believe this silence is due to any fault in Dr Gray who is highly regarded by his colleagues.

The other set of problems concerns the relationship of the employers (the Department of Health) to the professional staff undertaking the screening tests. The media take pride in revealing the "scandal" when Mrs X finds that she was wrongly told that she did, or did not, have cancer. It is indeed a very poignant human-interest story, but unfortunately one that is sometimes inevitable, given the fallibility of present screening technology. However, the response of the Minister is usually to call for an immediate enquiry into the competence of the relevant screening staff. If, after months of investigation, it is found that the error rate of this laboratory is not significantly different from the national average, this fact does not make headlines, nor does anyone feel the need to apologise. It is not surprising that it is difficult to recruit staff to screening posts.

Why has this sad state of affairs arisen? I think a clue is provided in a news item by Annabel Ferriman in the BMJ in February this year⁴. Two editors of the Western Medical Journal wrote a piece in the San Francisco Chronicle

saying that prostate cancer screening may cause more harm than good, and were ferociously attacked by advocates of prostate cancer screening, who demanded that they be sacked. A comment from (ironically) Dr Muir Gray agreed that the evidence supported the views of the editors. However prostate screening in the US is backed by a powerful lobby with financial interests in diagnosing and treating prostate cancer. In the UK the conflict of interest in cancer screening is not financial, but political. What health minister, having claimed credit for saving lives by screening, can afford to admit that maybe screening is, on balance, not such a good idea?

There is an easy solution to this problem. If the pros and cons of screening were openly and fairly presented some women (but probably fewer than at present) would still opt to be screened. The reduced load on the screening service would save resources, and the people being screened would know that the result of screening would be an opinion, not a guarantee. If the prediction from screening sometimes proved wrong it would still be very sad, but not a scandal. Sometimes, even for politicians, honesty is the best policy.

John Garrow
Hon Secretary, HealthWatch

References:

1. Editorial, Lancet Oncology, March 2002.
2. Olsen O, Gøtzsche PC. Cochrane review on screening for breast cancer with mammography. Lancet 2001; 358:1340–42.
3. Screening for breast cancer with mammography (correspondence) Lancet 2001; 358: 2164–68.
4. Annabel Ferriman. Advocates of PSA testing campaign to silence critics. BMJ 2002; 324: 255.

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OPINION

Why are we funding courses in dubious therapies?

...asks Paul Diamond, biochemist (now retired) whose career has spanned research, teaching at London medical schools and universities, and has co-authored scientific papers as well as a textbook on laboratory techniques. His son, the late journalist and broadcaster [John Diamond](#), received the [year 2000 HealthWatch Award](#).

In recent issues of the newsletter there was criticism of some of the broadsheet newspapers for publishing columns promoting alternative medicine by the "barefoot doctor" and similar journalists (HealthWatch Newsletter issues [43](#) and [44](#) and [see below](#)). One can show disapproval of this practice by not buying the paper and in some small way not giving them money.

Unfortunately there are other areas where this choice is not available. The London borough where I live publishes a prospectus for its adult education service which lists three pages of 'complementary therapies'. Besides sixty hours instruction on astrology and twenty hours on reading the tarot the prospectus lists courses in holistic therapies, aromatherapy, reflexology, Indian head massage and similar topics.

Some of these courses lead to 'professional' certificates and diplomas so that on completion and the passing of an examination the student can set up in business as a qualified therapist. The syllabuses and examinations are the responsibility of the official sounding Vocational Training Charitable Trust (VTCT). The web site for the Trust shows it to be an organisation set up specifically to promote complementary therapies. It claims to be recognised internationally as 'the largest awarding body for aromatherapy, reflexology, holistic therapies and beauty therapy'. Its banner proclaims its provision of 'Quality plus Qualifications for the World'. The VTCT courses do not appear to be particularly arduous. None of them seem to require any previous experience or qualifications. The certificate in reflexology demands attendance for two hours a week for thirty five weeks. The examination is described as 'for anyone who would like to become a professional therapist'.

The annual magazine Floodlight, which lists all the adult and further education opportunities in the Greater London area, advertises hundreds of these courses, not all of them VTCT, with most complementary therapy disciplines represented in dozens of colleges. The VTCT website lists colleges up and down the country which teach its syllabuses. It seems that practically every local education authority is involved.

To give just one example: a college in the Home Counties runs a one year full time diploma course in holistic therapies. These include reflexology, aromatherapy and nutrition counselling besides advice on setting up in business as a therapist. One of the subjects quoted is 'assess the client for holistic treatment'. When a doctor assesses a 'client' for therapy it is usually called diagnosis. Claire Rayner, at the Healthwatch AGM, expressed reservations about the recent suggestion that skilled professional and qualified medical auxiliaries like nurses should be given diagnostic responsibilities. Surely there should even more concern about people of very limited training setting themselves up as diagnosticians. The full time course provides instruction for three days a week. The other two days are spent at home doing course work and case studies. If the tutor thinks that a student is making satisfactory progress Indian head massage can be taken as an extra therapy.

Why education authorities who constantly complain about the squeeze on their budgets should be spending

money on these subjects is the first question to be asked. The usual answer is that there is a demand. There is, of course, a demand for many strange interests; one has only to list the more popular sites on the internet. But we are not forced to contribute our national and local taxes to support them. The millions of pounds that they cost could surely be put to better use.

What is much more serious is that, even if they did not require public subsidy and were fully self funded, it is not in the remit of public educational bodies, whose standards are believed to be closely monitored, to give the seal of authenticity and credence to practices whose benefits are at best unproven and whose effects are at worst positively harmful.

Paul Diamond

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NEWS FOCUS: MMR and autism link "unlikely"

When MMR vaccine is mentioned by UK media, they are more likely to depict families struggling with afflicted children than to give details of the evidence that the Health Authorities rely upon to decide the vaccine is safe, writes Michael Allen. Recent peer-reviewed evidence, however, draws a straightforward message:

The possible role of MMR vaccine in causing autism is deeply worrying; proponents of this theory are clearly honourable and dedicated doctors and scientists; the personal tragedy for families affected by autism is great.

The causal association seems highly unlikely because:

1. If MMR causes autism there would be a clear association between the date the MMR vaccine was introduced and the rise in autism. Autism is more common now than in the past, but the increase does not show a time relationship to the introduction of MMR vaccine.
2. The theory suggests a complicated mechanism whereby measles virus infects and damages the gut causing release of toxic materials which in turn attack the brain and cause autism; recent studies confirm the presence of measles virus in the gut of affected children. A new variant disease in which autism is associated with inflammatory bowel disease (IBD) is proposed. However, specific studies in the UK have shown that a new variant disease did not emerge after introduction of MMR; some children with autism do show IBD, but the proportion in whom this is found has not changed since the introduction of MMR vaccine.
3. The theory suggests MMR would cause more autism than individually administered measles, mumps and rubella, but there is no evidence for this. Use of single vaccines would replace a widely tested vaccine system by a relatively less tried system, with possible unknown risks.

It is not possible to prove a negative association nor can it be proved that no individual case of autism has ever been caused by MMR vaccination, but each proposition of the theory that there is a causative relationship has been shown to be invalid to date.

A detailed review with references to articles cited is from [here](#) as a resource for those who wish to study the matter in more depth.

If you do not have a copy of the Adobe Acrobat reader then you can download it from [here](#)

Michael Allen BPharm MRPharmS
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MEDIA

Barefoot Doctor or Barefaced Cheek?

The full version of this article by HealthWatch Committee member Neville Goodman originally appeared in The British Journal of General Practice in November 2001. This extract is reproduced here with the kind permission of the journal's editor.

Just over a year ago, The Observer began dedicating half a page to "an alternative look at health issues". Its author is Stephen Russell, who calls himself the "Barefoot Doctor". The Observer is a broadsheet, not a tabloid. I like to think that what I read in The Observer about Afghanistan, the economy, or the politics of the NHS is at least based on facts. It has a number of columnists for whom I have great respect—Nick Cohen and Will Hutton are two. Yet they share their newspaper with a man who writes nonsense. On one side of a page are serious medical discussions; on the other are fairy stories.

Those who read my regular column in the Back Pages of The British Journal of General Practice¹ may recall some of Stephen Russell's ideas of how the body works: the ears are the flowers of the kidney, so tinnitus is a result of depleted kidney energy; memory is not so good pre-menstrually because blood is diverted from the spleen,

which is the organ governing short-term memory. These are not Stephen Russell's ideas alone; they can be found in books about Chinese medicine. Every week, The Observer's colour supplement Life is publishing this rubbish.

After the column appeared, I sent it, with a letter of complaint, to the editor of Life. I wrote a short letter to The Observer, which appeared in their correspondence columns, pointing out that our understanding of how the body works has moved on in the last 5000 years. I enclosed a photocopy of the letter when I reminded the editor of Life that he had not replied. Eventually, I received a phone call from one of the editorial staff. She said they were passing my letter on to Mr Russell, and asked if that was what I wanted.

"No", I said. "What I want to know is why you're publishing this stuff."

"He's very popular," she replied.

"I don't doubt that," I said, "but it's nonsense." There was a short pause.

"Isn't it just another way of looking at things?", she asked.

"Yes, sure," I agreed, "in the same way that thinking the Earth is flat it is indeed another way of looking at things."

The conversation was going nowhere so I accepted her offer to pass on my letter and awaited Mr Russell's reply. It was prompt, and I will quote from it.

"...a readership with even a passing knowledge of a form of medicine that has consistently proven its efficacy over the last five millennia would be evolved enough to know that the liver is not actually a plant with the eyes as its flower. Likewise, the kidney and ears. You are of course right that if taken literally this is nonsense. [I hope] my readers are not immune to the wonders of poetry. I use these terms metaphorically."

There is no evidence in the orthodox sense that Chinese medicine as a whole has proven its efficacy (although some of its herbs are efficacious enough that they have side-effects). The Chinese are not notably more healthy than we are. They suffer different diseases; they do not yet suffer to the same extent the diseases of Western overconsumption and of longer life expectancy. The "evidence" that Chinese medicine works is anecdotal and self-fulfilling (if it's survived 5000 years it must be right).

I don't mind Mr Russell using metaphor. Analogy, for which metaphor is often used, is useful for explaining ideas, especially to people with no basic knowledge of a subject. When a patient is told that the liver is the power station of the body, or that the kidneys are part of a water purification system, that is metaphor. But no principle is being illustrated by referring to the eyes as the flowers of the liver. Poetry it may be, but it is nonsense poetry, which could seriously mislead given the limited understanding that many people have of anatomy and physiology.

Mr Russell goes on in his letter to say that we in the West must not become arrogant about the advances of orthodox medicine—which is true. He avers that he never denigrates Western medicine—which is also true. He does not criticise Western medicine, he writes, because he does not know enough about it to do so; he asks me to show the same respect, and ends his letter by wishing for an end to "pointless polarising".

I wrote back to Mr Russell. I have tried four times, politely but fruitlessly, to enter into further dialogue. He receives, according to a Life profile of him (8 July 2001), 30 to 40 e-mails every hour from all around the world asking for help. I don't know how many he manages to reply to, but he doesn't reply to mine.

The bookshops are crammed with books on "health fiction". It is easy to find examples of erroneous ideas about diseases, their causes and cures. It is finding them in a serious newspaper that is especially upsetting. Perhaps it is a little unfair to pick out Stephen Russell, who writes well, sympathetically, and with good humour when engaged on touchy-feely matters of how to live life less stressfully. But "pointless polarising" is not pointless and respect is not an option when possibly ignorant people are told that hair is controlled by kidney energy (8 October 2000); the kidney yin is responsible for the integrity of the knee joint (12 November 2000); palpitations are caused by deficient kidney chi energy not holding the heart in check (11 February 2001); skin tags on the neck are owing to the spleen not properly separating pure from impure fluids (25 March 2001); the spleen holds things up against gravity and if unbalanced causes piles (1 April 2001); vertigo arises from deficient liver energy causing weakness in the gall bladder meridian (15 April 2001); and the energy in the body passes through a different organ or bowel every two hours (1 July 2001). Mr Russell often precedes his explanations with "according to oriental medicine", but I could just as easily write that according to ancient Britons the nose is the cauliflower of the spleen. It would be wrong, and so is oriental medicine.

When Mr Russell explained that bedwetting occurs because of deficient kidney energy and that acupuncture was useful (22 July 2001), a urological colleague who specialises in enuresis wrote to the Press Complaints Council. Their answer was that Mr Russell's column was clearly entitled "An alternative look at health issues", and therefore no action was necessary. Perhaps a column titled "A revisionist look at history issues" is next; I dread to think what may appear in it.

As long as alternative medicine seeks explanations in terms of mysterious energy channels and organs governing

functions over which they have not the remotest control, then melding orthodox with alternative medicine is—to use a metaphor that is entirely appropriate—like devising university courses combining astronomy with astrology. There is no place for this in the NHS, and there is no place for it in a serious newspaper.

Neville Goodman
Consultant Anaesthetist, Southmead Hospital, Bristol

Reference: The British Journal of General Practice. 2001; January: 85.

See also the article by Neville Goodman in [Newsletter no 43](#)

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ALTERNATIVE THERAPIES

And now for another miracle cure for cancer

Press reports of apparently miraculous recoveries from cancer attributable to alternative therapies are not unusual. But, as Caroline Richmond explains, where cancer is concerned the story is never black and white.

“Do you see the Sunday Times?” asked Michael Allen, HealthWatch’s press officer. “No”, I replied, tartly, “I regard it as the equivalent of the US’s National Enquirer, full of preposterous and unbelievable stories”. Michael wanted to talk about a first-hand account of a man’s escape from the clutches of an incurable cancer, myeloma, using alternative therapies, and in particular, coffee enemas. Maybe he asked me because I, too, have an incurable cancer, albeit a slow one: low-grade non-Hodgkin’s lymphoma. Myeloma, lymphoma, and leukaemia are similar. A day later, I was ploughing through the Sunday Times’s four-page account.

In essence, Michael Gearin-Tosh, which appears to be his real name, is an Oxford don and Senior Tutor in English. In 1994 he had night sweats. Paracetamol didn’t help. A specialist diagnosed myeloma and advised early treatment, which would prolong his life expectancy from about one year to two or three. Second and third opinions confirmed this, as did medical textbooks, journals, and phone conversations with several of the world’s leading oncologists.

After embracing a veggie diet, supplements, and bone-breathing exercises, and consulting a number of alternative therapists, Gearin-Tosh consulted a Dr Jan de Vries, author of books on alternative medicine. De Vries could tell by looking at him that he did not need chemotherapy. To his already complicated therapeutic armamentarium, Gearin-Tosh added Leslie Kenton and her book on the wonders of raw foods (fancy some raw potato?), a Vietnamese acupuncturist called Dr H He, and Gerson Therapy, named after Max Gerson, an American who advocates coffee enemas. These are said to open up the gall bladder and allow toxins to leave the body. Dr Gearin-Tosh took a gallon a day per rectum. Each to his own.

Seven years later, Dr Gearin-Tosh is still alive. He says that he skips some of the coffee enemas, and sometimes eats forbidden foods. I like him for that. He regularly sees an oncologist in London, and Sir David Weatherall in Oxford. His cancer treatments, enemas, injections and so forth take up a substantial amount of his day. He is ‘sub-anaemic’, his ‘immune system is disordered’—whatever that means—and his bones are fragile. He does not say whether he has accepted any orthodox treatment. But he is alive. His pale but smiling face shines out from the page.

Well, what can I say about all this? I have written about my own cancer, and my treatment with a monoclonal antibody, in the British Medical Journal and the Oldie. I gave the BMJ my permission to check the facts with my oncologist at the Middlesex Hospital, though as far as I know, they did not feel the need to do so. But the point is that no-one, and no publication, can normally check the accuracy of a patient’s account, because of confidentiality. You can never know for certain, first-hand, what my or Dr Gearin-Tosh’s diagnoses were, or whether our doctors agree with what we write.

A retired oncologist once told me that he has seen two inexplicable remissions from advanced cancer; in neither case, as far as he knew, was the patient using alternative therapies. Friends sometimes tell me about miracle cures in people they have known. I urge them to ask the friend to get their oncologist to write them up as a case report for one of the medical journals. None of them has done so.

In my younger and more headstrong days I used to fume at the way articles like this could entice cancer patients to an early grave. Now I am more tolerant. I find that most people with cancer will take the orthodox treatment as well, just to be on the safe side. I now believe that if a person is determined to do something, however irrational, it is their body, their life, and their right to do so. I have known doctor friends, now dead, who have called a halt to treatment of their fatal illness. Among them was Petr Skrabanek, Professor of Community Health at Trinity College Dublin, and a founder-member of HealthWatch.

In those headstrong days I often wondered whether I might feel differently about alternative therapies if I had cancer. Now that I have, I feel no desire to use them. I don’t even see my oncologist as often as recommended, and have fewer scans. I periodically e-mail him to tell him I’m fine, and that’s why I have postponed my next

appointment, and he will see me at short notice when I have a problem. This system works well: when I developed a tumour over my left eye last autumn, it was scanned—to assess it—and irradiated promptly. (The tumour rapidly vanished.) I find myself more concerned with quality of life than with quantity, and my quality of life is at least 90% of what it would be without the lymphoma.

I have had two courses of radiotherapy. Both effectively removed the tumours in their path. One course gave me an exquisitely painful sore throat for a week, and the other had no adverse effects. I've had six months of oral chemotherapy, which didn't make much difference. And I've had two spectacularly successful courses of the monoclonal antibodies, to which I owe my life and health. I now have tumours that do not respond to it, but they hardly bother me. I have never had the slightest pain from my cancer. Like Dr Gearin-Tosh, I was diagnosed in 1994. My bible is Everyone's Guide to Cancer Therapy by Dollinger and others. The Canadian Medical Association, for whose journal I write, endorses it. It says, incidentally, that there are indolent forms of myeloma, and patients who have them can survive for years without treatment. My next-favourite book, What You Really Need to Know about Cancer by Canadian oncologist Rob Buckman, says that myeloma is usually a slow-growing cancer, and most cases can be controlled for a long time without radiotherapy.

Meanwhile my quality of life is at least 90% of what it would be without the lymphoma. I work part time for a science pressure group, write jokey articles for the Oldie, and obituaries of dead doctors for the BMJ and Independent.

To end with: Rob Buckman says that those enemas ruin the taste of the coffee.

Caroline Richmond
Medical Journalist and HealthWatch Committee Member

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MEETING REPORT

Must there be an alternative?

Complementary Medicine Day was the open-ended title to the final training day in the run up to Christmas for the Guildford GP Registrar training scheme. GP training is a breath of fresh air after a hospital training, which often seems to lose sight of the patient in the quest for clinical excellence. The treatment of disease is sadly often at the expense of the dignity of the patient as a human being. The GP Registrar year, on the other hand, has the noble aim of reintroducing the doctor to the patient, a person with their own life and context, and their own ideas, concerns and expectations.

Listening, hearing the others' points of view, not wishing to judge, or criticise—in short being “open-minded”—are the new skills of the modern GP. This aligns nicely with current cultural ideals of tolerance and relativism. Patient and doctor both bring baggage to the consultation and the aim is to negotiate and arrive at some mutually acceptable arrangement. Gone are the days of paternalism, in General Practice at least.

Before our session on Complementary therapy, we had been advised to attend a therapist or interview one for ourselves. A quarter of us did; I visited two. In groups of four we shared our experiences, discussing the issues raised, before reconvening to share the issues as a larger group.

The anecdotal results of a group of 15 GP Registrars are as follows: Much talk along the lines of, “I tried it and felt better” (what was wrong in the first instance?), and “the proof of the pudding is in the eating” (puddings being as effective as ...?). “It makes people feel better”, “What's wrong with placebo?”, “there's not much evidence for most of what GPs do anyway”, “the history of medicine is full of changes in direction”. I could only say, “but”, so many times. A frenzied atmosphere of mutual acceptance and tolerance is a dangerous place for a sceptic. Evidence? Well it's hard to rely on evidence. Integrity? I'm just happy if my patients feel better. Objectivity? That's a heresy isn't it? Truth? Yours or mine?

Apart from my being the model of the heartless rationalist, there were few dissenting voices. I persisted, “Here are some back issues of the Healthwatch newsletter,” “I recommend John Diamond's ‘Snake Oil’”. All of which seemed to pale next to the revelation that, “we are privileged that one of the GP Registrars is doing a course in Reflexology”. Privileged that one of the GP Registrars is highly sceptical of Alternativism? In another world, perhaps.

Was it all worth it? Did I win any converts as I handed out Healthwatch tracts? I was glad to be able to contribute, to stand against the tide of acceptance, but I don't think I did much more than make people smile at my enthusiasm. The issue just doesn't drive the passions. Live and let live, and if it feels good, well it seems a little trite to start pointing to truth or evidence. I am not even sure, despite my pointed comments, that people realised that there was a debate on. I received few disapproving glances, and I tried very hard.

Debate implies two opposing views, when to modern eyes a view is seen as nothing more than an opinion with no relation to reality. It is neither true nor false: just different, and that is not something to disagree about. It would be impossible to convince the others when they had no strong view in the first place, did not disagree

strongly either with the believers or the sceptics, and did not see that it mattered.

Unfortunately this debate runs deeper than simply understanding the concept of evidence; it lies at the heart of modern culture. GP trainees, like most modern people, do not see truth and falsehood: they are relativists to the core. Truth is seen as subjective opinion, and my whims on the subject of alternative medicine are merely another alternative. They heard my ideas, concerns, and expectations and accepted them along with those of Complementary therapy.

It is difficult not to give in to the anti-intellectualism of political correctness. It is tempting to sacrifice one's belief in reality and truth if only for a bit of peace and quiet. If there is anything that gets modern GP trainees slightly inflamed about their views, it is when someone tries to persuade them that they are wrong to believe in nothing. (Simultaneous acceptance of two mutually contradictory positions as equally valid is belief in nothing.) It is remarkably difficult to get people to realise that that is what you are suggesting, but if achieved one is likely to be dismissed as intolerant. There are few things today that are defended with such passion as belief in nothing. Some alternatives are real alternatives, but they are sadly unacceptable.

James May is a GP Registrar at Woodbridge Hill Surgery in Guildford on the Guildford Vocational Training Scheme.

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SITES TO SEE

Questionable assumptions about the use of dietary supplements are robustly debunked on the US Food and Drug Administration's new Tips for the Savvy Supplement User website. There are cautions about supplement-drug interactions as well as tips for assessing manufacturer claims and news stories. See it on <http://www.cfsan.fda.gov/~dms/ds-savvy.html>.

For all those whose interest was stirred by Caroline Richmond's article on bioterrorism (HealthWatch [Newsletter 44, January 2002](#)) 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.

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LETTERS TO THE EDITOR

HealthWatch "not even-handed" says Chalmers

From Professor Iain Chalmers of the UK Cochrane Centre, a leading research group for evidence-based medicine:

Dear Editor

The first paragraph of Jan Willem Nienhuys' article "A tragic death from "untreated" breast cancer" (HealthWatch [Newsletter 44, January 2002](#)), states that Sylvia Millicam rejected "regular treatment with its 80 or 90 per cent survival". What message does this statement convey, coming as it does from a board member of the Dutch organisation Skepsis, and published in the Newsletter of an organisation promoting 'treatment that works'?

There have been important advances over the past decade or so in identifying treatments that reduce mortality from breast cancer; but to imply that they have been responsible for achieving an 80-90 per cent survival is grossly misleading.

Not only will this statement mislead readers who wish to have valid information about the effects of orthodox treatments for breast cancer; it is further evidence in support of those who maintain (as I have done since I became a founder member) that HealthWatch is not evenhanded in its scrutiny of claims made on behalf of orthodox and alternative medical practice.

Yours sincerely

Iain Chalmers

Author Jan Willem Nienhuys replies:

I meant only to convey that with treatment one has much better chances of surviving than without any proven treatment at all. The so-called Integral Cancer Centers in the Netherlands provide overall statistics for the

five-year survival of breast cancer. Their publication for 2000 is based on all available Dutch data in the period 1988–1994. If during an operation for breast cancer metastases were found in the armpit lymph nodes, the survival rate is 70–80%. If the cancer was restricted to the breast only, the survival rate is 80–95%. Both rates apply to full treatment, a combination of surgery, chemotherapy and radiation therapy.

These rates are overall rates, comprising aggressive forms in young women and slowly growing forms in old women. The prospects may very well be much poorer for a young woman who only seeks expert help half a year after finding a lump.

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LETTERS TO THE EDITOR

Complementary medicine succeeds where orthodox fails?

David L. Crosby, Honorary Consultant Surgeon at the University Hospital of Wales, writes:

Dear Editor

In his book review of the late John Diamond's admirable "Snake Oil and other Preoccupations", Geoff Watts refers to some of Diamond's explanations for the current and expanding popularity of complementary and alternative medicine (HealthWatch [Newsletter 43, October 2001](#)). It seems to me that addressing this question comprehensively, and understanding the explanations, is an extremely important exercise for all practitioners of orthodox medicine, and one of the ways in which we can acknowledge John Diamond's remarkable bravery and penetrating insight. Those that doubt the scale of the issue need only observe the shelves in local chemist shops, the yellow pages in telephone directories and the growing number of high street "Natural healing" clinics. It is a multi-billion pound industry, and the number of its practitioners must surely now exceed that of orthodox practitioners.

It might be questioned why we need be concerned that so many of the population are willing to spend their money on dubious remedies, and that it might even be of benefit if it keeps the burden of the "worried well" away from surgeries, clinics and waiting lists.

But there are underlying and deeply worrying causes for concern. Apart from the well recognised delays in effective treatment and the waste of money by those who can ill afford it, there should also be the recognition that to a considerable extent, complementary medicine succeeds where orthodox medicine fails. At the very least, it must indicate where we fail to provide sufficient comfort and explanation to those whose physical and mental illness we cannot relieve completely. Even more disturbing is the growing number of orthodox practitioners who appear more than willing to "integrate" their NHS work with evidence free therapies. Indeed, even the BMA can now be included in this trend and apparently supports the view, if only by default, that more NHS resources should be expended in this direction. It may be that Royal blandishments have precluded open criticism of the nonsense that often emanates from that direction.

It may be that the size of this problem now exceeds our ability to influence it effectively. However, at the very least, we should be lobbying our medical schools about the integrity of their graduates, and the BMA about its principles.

Yours sincerely

DAVID L CROSBY

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LETTERS TO THE EDITOR

How contagious is smallpox?

Dr Gus Plaut, a HealthWatch member in Halstead, Essex, writes:

Dear Editor

The article by Caroline Richmond on Bioterrorism (HealthWatch [newsletter 44, January 2002](#)) is good and reassuring, but I doubt her statement that "you can only catch it (smallpox) from someone who's got it." The very last case of smallpox in this country was, as I am sure you remember, in a Birmingham laboratory in 1978, when a photographer caught the disease from the ventilator that had been effective in the laboratory on a different floor, at which research was being carried out on the virus. The unfortunate photographer died of smallpox, and the professor committed suicide. The smallpox virus is highly contagious.

Yours sincerely

LAST WORD

Scientific terms need protecting

I would certainly join a Society for the Protection of Scientific Terms. The urge was particularly strong after I had experienced Shiatsu, which is like acupuncture without needles, not unpleasant. But I was then told that I had very low kidney energy. The idea that pounding and pressing bits of my body could detect such a localised quantity was irrational, absurd, and finally infuriating.

Science is supposed to use words with care and preferably with strict definitions. Non-scientists have, not for the first time, taken a scientific term and used it in a way that seems to be totally inappropriate; but because the word is from science it gives it a spurious validity—just think of chaos, relativity, and the uncertainty principle. Nowhere is this more evident than with the widespread use of the term energy in what is politely called alternative or complementary medicine, but bears no, or little relation to science-based medicine. I recognise that the word may have been used long before the scientific basis of energy was established, but that was some 200 years ago.

Greek philosophers thought of energy as a fluid permeating a substance. Energy medicine apparently accepts the existence of a subtle energy system within the body, holding that manipulating the body energetically can cause physical, material changes to take place. Matter and energy are understood to be completely interchangeable—in fact, they are regarded as being, ultimately, the same thing. (Linking this with Einstein's ideas is totally spurious). The body is viewed as an integrated whole. Thus Ayurvedic medicine claims that there are canals in the body carrying energy and qi energy channels are central to acupuncture, crystal healing is based on transmission of energy, and faith healing also works by channelling energy. There is no indication of how this energy is generated or what its nature is.

One of the earliest uses of energy, psychic energy, was that of Freud which provided a hydraulic model of the mind. He suggested that the operation of the brain was governed by the energy of the nerve cells which tried to keep the energy to a minimum. Repression for example, requires constant expenditure of energy by the Ego. He proposed that all laughter-producing events are pleasurable because they save psychic energy.

All this bears no believable relation to the fundamental concept of energy used in science. Energy is the capacity for doing work as recognised by my hero Galileo. Lifting a weight by a pulley requires a force moving through a distance and the product of the force and the distance is work and is equivalent to energy. The unit for energy is the joule which is defined as force of one newton acting over one meter. All energy is associated with motion—the lifted weight has potential energy for moving down when it is converted into kinetic energy. There is also chemical energy in the movement of molecules and thermal energy from heat. Energy is never lost, merely converted into another form. The main source of energy in our world is radiation from the Sun produced by thermo-nuclear reactions.

Cells use energy to maintain their complex organisation and to grow and multiply and move. This energy comes from chemical reactions. The currency for most energy requiring processes in cells—the cell's "euro"—is adenosine triphosphate (ATP), which can provide energy when one of the three phosphates is removed. The food we eat together with oxygen generates the ATP currency. It is ATP that provides the energy for the function of our liver, kidneys, and brain. There is no evidence for a chemical or biological entity such as qi or kidney energy. Such misuse of a scientific term does matter for it gives a false credibility to the explanations offered as to how treatments such as acupuncture might work. I am not suggesting here that the techniques of alternative medicine do not help patients or that their effect is entirely due to the placebo effect but it is totally misleading to claim that energy underlies their effect. The continued misuse of the term should make one very suspicious of those who persist in misusing it.

Lewis Wolpert
Professor of Biology as Applied to Medicine
University College London

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