



Health Watch

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Newsletter 58 July 2005

AWARD FOR TOP CAM RESEARCH LEADER

EDZARD ERNST, the UK's first and only professor of complementary medicine, is to receive the 2005 HealthWatch Award at the next Annual General Meeting in October.

Since he established the Laing Chair in Complementary Medicine at the University of Exeter (now the Peninsula Medical School, a joint school of the Universities of Exeter and Plymouth) Professor Ernst has published over 700 articles in peer-reviewed medical literature, reporting on quality studies of the safety and efficacy of a wide range of complementary and alternative (CAM) treatments. Ernst originally qualified as a physician in Germany, then received training in acupuncture, autogenic training, herbalism, homoeopathy, massage therapy and spinal manipulation. He is not, however, an unquestioning advocate of these treatments. On the contrary, he has made it his mission to subject complementary therapies to the kind of stringent testing that is mandatory for

orthodox ones, and together with his team at Exeter they have created—and continue to expand—a substantial evidence base of a uniquely high quality. An author of more than 30 books, he has already received eight scientific prizes. Not surprisingly, as this country's foremost authority on complementary medicine his opinion is frequently sought by the media—he also writes a brilliant column for the *Guardian* every Thursday (see www.guardian.co.uk).

Professor Ernst will receive his award on Thursday 20th October at the seventeenth HealthWatch Annual General Meeting at the Medical Society of London, where he will present a talk titled: "Complementary and Alternative Medicine: the Good, the Bad and the Ugly."

How did an advertisement for a cosmetic claiming to cure psoriasis and eczema appear in three national newspapers?

A "NEW UNISEX organic cream" promoted as a remedy for psoriasis and eczema has caused a stir after three national broadsheet newspapers carried large advertisements repeating product claims that appear to fall foul of the code of advertising practice.

Freelance journalist Naomi Marks, writing in the *British Medical Journal*, investigated how advertisements for Cashmere Beauty apparently slipped through the normal vetting procedures to appear in the *Times*, the *Independent*, and the *Guardian*. The ad, which in the *Guardian* was 20 cm high and across two columns, was headlined "Psoriasis & eczema remedy discovered" and claimed the product to be "an effective alternative to toxic prescriptive products treating Psoriasis, Eczema or any irritated complexion", also claiming to treat scar tissue, bumps, mild acne and stretch marks. It further stated that the product was "dermatologically tested and FDA approved."

Now the UK Advertising Standards Authority (ASA) is investigating whether or not the advertisement violates the British Code of Advertising, Sales Promotion and Direct Marketing.

Under the code (www.asa.org.uk/asa/codes/cap_code/), strict guidelines govern the use of terms such as "remedy" and "heal";

products making such claims must be licensed by the Medicines and Healthcare products Regulatory Agency. Cashmere Beauty has no such licence.

Experts interviewed by Marks, including a professor of dermatology and an executive of the Psoriasis Association, expressed concern over false hopes raised amongst vulnerable patients.

A spokesperson for the ASA said the strength of the self regulatory system of newspaper advertising in the UK lay in the fact that if an advertiser would not voluntarily stop running an offending ad, then publishers would not take it. In fact, out of the UK national broadsheets, only the *Daily Telegraph* queried the ad with the authorities and the paper refrained from publishing it. It remains incumbent upon publishers to ensure ads conform to both the ASA's guidelines and the law in the first place. In the case of Cashmere Beauty, that system proved unreliable.

British Medical Journal 2005; **330**: 1092 (7 May)

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Don't be misled on the web

THE EXTENT of misleading health information on the Internet was highlighted by the *BMA News Review* recently in an article that featured an interview with HealthWatch's vice-chairman, Dr David Bender.

Type the words "cancer" and "treatment" into the Google search engine, suggests the article's author Polly Newton, and you get 17.5 million results—some from websites run by respectable organisations, but many others offering crank cures, such as the company selling a £50 e-book detailing a secret herbal formula and diet that claims to help you beat the disease. So what can be done? "Nothing," says Dr Bender. "Anyone can set up a website".

The article recommends two starting points for tracking down reliable health information on the web. NHS Direct Online's pilot system, known as NHS Information Partners, recognises providers of quality-assured, evidence-based health information and allows them to flag themselves accordingly. You can find them on www.besttreatments.co.uk. Another recommended site is Organising Medical Networked Information (OMNI) which is a gateway to evaluated, quality online resources in health and medicine aimed at students, researchers, academics and practitioners: www.omni.ac.uk.

BMA News Review Saturday 16 April 2005, page 13

Patient-centred view of drug risks

PATIENTS, doctors and drug companies often have very different ideas about what constitutes a risk, writes HealthWatch committee member Dr Andrew Herxheimer in an illuminating article in the online journal *PloS Medicine*.

For example, the deepening of the voice that is a side effect of treatment with the breast cancer drug Tamoxifen may be considered so trivial as to be ignored by manufacturers and prescribers, yet could have profound effects upon the lives of patients whose voice quality is crucial to a career or hobby.

Dr Herxheimer's article offers a rare patient-centred view of the ways medical professionals present the probabilities and nature of harm associated with medical treatments, and offers some wise advice that manufacturers and prescribers would do well to heed.

The invaluable Public Library of Science website <http://medicine.plosjournals.org> offers peer-reviewed articles that are available to all to access and reproduce, free of charge.

PloS Medicine 2005; **2** (2): e42 DOI: 10.1371/journal.pmed.0020042

The MHRA: changing for the better?

CHANGES under way at the Medicines and Healthcare Products Regulatory Agency (MHRA) hold promise for advance, says an editorial in the *British Medical Journal*.

The developments follow a damning report earlier this year from the House of Commons health select committee. The MHRA's two advisory bodies—the Medicines Commission and the Commission on the Safety of Medicines—are to be replaced by the Commission on Human Medicines (CHM) which will advise on drug safety and

make licensing recommendations. The bodies will have their own standing committees to advise ministers directly; and the expert advisory groups that scrutinise licence applications will include lay members as well as senior medical professionals. The MHRA will also have a new advisory committee on herbal medicines. Members' personal interests must be declared and will exclude members from chairing committees or taking part in certain discussions.

British Medical Journal 2005; **330**: 917

NEWS IN BRIEF

THE *DAILY MAIL* commemorated the 250th birthday of homoeopathy's founding father, the German physician Dr Samuel Hahnemann, with a stinging condemnation of this popular alternative treatment. In an article titled, "Homoeopathy—undiluted tosh!" Michael Hanlon, the *Daily Mail's* Health Editor, declared, "I find this modern British faith in homeopathy extremely depressing...it represents an assault on the Age of Reason". He dismissed reported cases of cures as anecdotal, condemned the treatment's lack of scientific basis, questioned the public's perverse preference for witchcraft over enlightenment, and concluded that if you have a serious medical problem, "go orthodox. After all, it must say something that homoeopathic hospitals rarely have a casualty department."

Daily Mail, 12th April 2005, view on www.dailymail.co.uk/pages/live/articles/health/healthmain.html?in_article_id=344594&in_page_id=1774

THE MIDDLESEX Hospital in London has appointed a Reiki practitioner, funded by the NHS, to treat young leukemia patients suffering from the side effects of chemotherapy. Several times a week, in private sessions lasting 30 minutes Graham King, 57, places his hands on different parts of the youngsters' bodies. Reiki is an ancient Tibetan technique whose name means, "universal life force energy" and its practitioners, or Masters, believe their hands

can "align" the recipient with the vibrations of the "universal life force", enabling them to receive the healing "energy" that flows from the Master's hands. Edzard Ernst, professor of complementary medicine at the Peninsula Medical school, says of the technique, "Scientifically it's implausible."

Time, 28 March 2005, view on www.time.com/time/columnist/jaroff/article/0,9565,1042639,00.html

ACUPUNCTURE is no more effective than sham treatment in reducing migraine headaches, says a report in the *Journal of the American Medical Association*. One person in 10 people experiences migraine headaches and most orthodox treatments show no more than modest success. In a trial at the Centre for Complementary Medicine Research in Munich, Germany, 302 migraine patients were randomised to receive either acupuncture or sham acupuncture in 12 sessions per patient over 8 weeks, using waiting list patients as controls. The sham treatment consisted of needles placed at non-acupuncture points. The authors found that both real and sham acupuncture reduced the number of migraine headaches compared with no treatment; and the result may be due to nonspecific physiological effects of needling, to a powerful placebo effect, or to a combination of both.

JAMA 2005; **293**: 2118–2125

FIFTEEN SECONDS OF FAME: HOW TO MAKE THE MOST OF AIRTIME

Medical writer and HealthWatch Committee member John Illman has wide experience in training individuals to perform well in television interviews. After a few precious moments on the news your views could be on everybody's lips, or have vanished into thin air. Here he shares some valuable advice for any experts facing the prospect of having fame—or at least, a microphone—thrust upon them.



IMAGINE you are a world authority on immunology. You have just been appointed to head a prestigious university department. A TV science correspondent calls over the weekend about a new development in your field. You have never been on television before and never had any training in how to present your case to a journalist, but you pride yourself on your communication skills. You know your subject: you have lectured all over the world.

In the studio, you find yourself competing for air time against an earthquake in Chile, a UN world summit, the death of a Hollywood star and arms negotiations in Geneva. You are given only two minutes on air and the interview leaves you frustrated and upset because you make every possible effort to answer the questions, leaving no time for what you actually wanted to say.

You could have taken the initiative using a simple ABC technique—Acknowledge, Bridge, Communicate. For example, you may acknowledge a question by saying: “That’s an interesting point, but I’d like to say...”, “You say that, but that’s not quite right...” or, “We don’t think that’s the case, we believe that...”. Phrases like these create verbal bridges from which you can communicate your key messages. (Yes, politicians use this technique, except many of them don’t bother with A or B—they go straight to C, and it sounds terrible.)

It won’t work, however, unless you know exactly what points you want to make. This might seem so obvious as to be superfluous, but doctors and scientists often lose their way in the face of aggressive questioning. The journalist may drive the interview agenda at their expense unless the expert can keep two or three “key messages” in the forefront of their mind throughout the interview. The challenge is to keep bridging back to these key messages and supporting them with evidence: statistics, examples, anecdotal case histories.

“Scientific news stories almost invariably begin at the end...there’s a reason for this”

Key messages should be short, snappy and simple. Try ‘the elevator test’—getting your message across between the first and third floor of a hotel, when the person you are talking to is due to get out. Allow 10 to 15 seconds or so per message. Stick to two or three key messages in an interview. Key messages can either be simple statements of fact or a slogan which may provide a headline or a broadcast clip.

I can hear critics saying: “Oh, this is trivialising science. The media is just terrible”. But the media reflects public demand, perhaps your personal demands. Think how you read your newspaper. Most of us don’t read newspapers. We scan them, spending perhaps three or four seconds on a headline and the first paragraph before passing on. Of the 150 or so news items in a typical broadsheet newspaper, how many do you read from beginning to end? The elevator test simply demonstrates the process billions of people use each day to evaluate news.

In preparing key messages, try to think in three dimensions. Most interviewees are one-dimensional and think “What’s in it for me?” Good interviewees think in three dimensions: “What’s in it

for the journalist? What’s in it for the audience? What’s in it for me?” No, you can’t please all the people all of the time, but your chance of success will increase immeasurably if you try—and if you try to keep it simple.

The paradox is that preparing a key message that is “as simple as possible, but not any simpler”, to quote Einstein, is anything but simple. Pascal recognized this when he wrote: “I have only made this letter longer because I have not had the time to make it shorter.” Many scientists spend far more time preparing presentations than media interviews, even though they have significantly more control over the former (at least, until question time).

EFFECTIVE media communication also means turning traditional scientific training—with its emphasis on ‘beginning, middle and end’—on its head. Scientific news stories almost invariably begin with the ‘end’. There is a good reason for this. If every news story included background information of the kind many scientists traditionally provide by way of introductory information, we would need wheelbarrows for our daily newspapers and the average broadcast interview would run to 10–15 minutes. Enough news already arrives at any large newspaper office or TV or radio station each day to fill four or five fat novels and flood news columns and air time several times over. News stories and interviews have to start with the ‘end’—the most important message or conclusion—because any delay and the audience may have stopped listening, turned the page or switched channels before they even know whether it might have been of interest.

Thus, the interviewee needs not only to know his subject, but to know *how much the audience needs to know*. Think of this page as representing the sum total of your specialist knowledge. Take a pin and insert it into any one of the words of the last sentence. That tiny pinprick will probably represent all you need for a typical consumer media interview.

For example, take a BBC TV interview with a haemophilia specialist about a 12-year-old boy who had a blood transfusion from a donor with Creutzfeldt-Jakob disease (CJD). The interview ran for two minutes 20 seconds (452 words). The doctor had 238 words to explain ‘this terribly distressing case’. (By way of comparison, this paragraph contains 70 words). His problem was compounded by interruptions and the need to correct the interviewer twice.

What this suggests is that a media interview is about as far removed from everyday conversation as President Bush is from Iraq. Everyday conversation conditions us to answer questions, and answer them fully, but what works well over the morning coffee break is potentially disastrous in a two or three minute broadcast interview. So when you get that call it’s time to set your own agenda, prepare and rehearse your key messages...and perform.

John Illman
Medical Journalist and Author

EMDR: OF LIMITED USE, WHICHEVER WAY YOU LOOK AT IT

Shortly after the December 2004 Tsunami disaster, the National Institute for Clinical Excellence recommended a controversial form of therapy called Eye Movement Desensitisation and Reprocessing (EMDR) for the treatment of post traumatic stress such as that being diagnosed in those affected by the tragedy. In EMDR an individual is asked to create and hold in their mind a picture of the worst moment during the disaster, while following the movement of their clinical psychologist's fingers with their eyes. The psychologist instructs the patients to "let the image go freely where it wants to". Some proponents believe this process has the power to unlock traumatic memories. Others are sceptical, among them psychologist Dr James Ost, an advisor to the British False Memory Society

THE NATIONAL Institute for Clinical Excellence (NICE) recently commissioned a report evaluating various treatments for Post Traumatic Stress Disorder (PTSD)¹. This report examined the evidence base for several trauma-focussed, psychological treatments including Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR).

The authors of the report conclude the effectiveness of EMDR was generally supported by the results of their meta-analysis but, "... the evidence base was not as strong as that for trauma-focused CBT, both in terms of the number of RCTs [Randomized Controlled Trials] available and the certainty with which clinical benefit was established" (see page 61 of the NICE report¹)

Despite the limited data available, the authors were able to draw some conclusions. They argued that there was limited evidence favouring the efficacy of EMDR over waiting list controls on various measures. This is not surprising and can be attributed to various non-specific treatment effects (e.g. the expectation for improvement and therapist attention^{2,3}). The authors also found inconclusive evidence of any clinically important differences between EMDR and other treatments (e.g. trauma-focused CBT, stress management; see also Taylor *et al*⁴).

"The findings of the report, as well as the psychological literature on efficacy of EMDR, do not warrant NICE's recommendation."

These findings concur with a critical analysis of EMDR⁵ published in 2003 which concluded that "comparisons with effective treatment or effective treatment components show the relative effects of EMDR to be weak or negligible" (see page 254 of that report; also Devilly's report⁶ from the previous year). Nevertheless, the authors of the NICE report concluded that:

"[A]ll PTSD sufferers should be offered a course of trauma-focused psychological treatment (trauma-focused cognitive-behavioural therapy or eye movement desensitisation and reprocessing)"⁷.

The findings of the report, as well as the psychological literature on efficacy of EMDR, do not warrant such a recommendation. The NICE report drew on a limited sample of the studies that have been conducted into the effectiveness of EMDR and, in doing so, failed to acknowledge the reservations about EMDR that have been

expressed elsewhere in the psychological literature^{2,3,5,6,7,8,9,10,11,12}. While there are many reasons for urging caution in interpreting the findings of EMDR research only two will be discussed here. The first concerns the way in which the outcomes of EMDR treatment are evaluated, and the second concerns the weak theoretical underpinnings for the novel components of the treatment.

How EMDR interventions are evaluated: Evaluations of the efficacy of EMDR have typically taken two forms—comparative studies and dismantling studies. The NICE report only considered the former which aim to compare EMDR to other established techniques, such as CBT, relaxation training and exposure therapy⁴. Comparative studies generally indicate, in accordance with the findings of the NICE report, that there is no evidence that EMDR produces more positive clinical outcomes than CBT, relaxation training, or exposure therapy⁸. Indeed there is limited evidence that, compared to established techniques, the outcomes of EMDR are sometimes less favourable⁴.

The second way to evaluate the effectiveness of EMDR (which the NICE report did not consider) is to conduct dismantling studies to determine which, if any, of the specific components of the intervention (in this case, eye movements, desensitization or reprocessing) have any unique effect in producing positive clinical outcomes. What dismantling studies have shown is that the eye movement component (EM) is inert and has no unique effect in terms of inhibiting negative emotions¹², or in producing desirable therapeutic outcomes^{14,9}. Even the technique's originator Shapiro¹⁵ has acknowledged that eye movements may be an unnecessary component of the treatment. Furthermore, Cusack and Spates⁷ found that the reprocessing element (R) did not contribute to treatment outcome. If the eye movement (EM) and reprocessing (R) components are inert then any indicators of positive change in EMDR studies, including the comparative studies cited by the NICE report, are likely to be the result of either the desensitization (D) component that is common to many other interventions, or non-specific treatment effects^{4,5,7,8,10,14,16}. As desensitization has

NICE responds:

"THE GUIDELINE is based on the best available evidence. For the guideline all relevant, high quality studies of EMDR were reviewed and this demonstrated there is a solid body of research evidence supporting the use of EMDR as an effective treatment for PTSD. All NICE guideline recommendations are supported by a robust peer review process and go through two rounds of public consultation to ensure the rec-

ommendations have received wide external validation and acceptance."

The National Institute for Clinical Excellence is now the National Institute for Health and Clinical Excellence (still known as NICE, but now incorporating the functions of the Health Development Agency). The web address for the new organisation is www.nice.org.uk

long been a staple of many effective interventions and is not unique to EMDR, McNally¹⁷ (see page 619 of that report) concluded that “what is effective in EMDR is not new, and what is new is not effective.”

Weak theoretical rationale: Given that dismantling studies show that the novel EM and R components of EMDR are inert, why do the technique’s proponents claim that these components are necessary? According to the technique’s originator¹⁵, EMDR is based on the assumption that memories for traumatic experiences are stored differently from memories of non-traumatic experiences. Specifically, she argues that “... human beings possess a physiologically based information-processing system that, under normal circumstances, will naturally respond to and resolve everyday minor disturbances. However, when a trauma occurs, this system can become imbalanced, causing the information to become ‘locked in the brain’ in the form it was input ... This information remains in neurobiological stasis ... and is thus incapable of effecting the appropriate connections that would allow the resolution of the traumatic event to occur.”

Shapiro argues that the eye movement (EM), or bilateral stimulation, component of EMDR treatment allows the traumatic information in ‘neurological stasis’ to be ‘unlocked’ and then reprocessed (R). However, the validity of this claim is also not supported by the psychological literature¹².

Firstly, the claim that memories for traumatic experiences are somehow ‘stored’ differently from memories for non-traumatic experience is controversial^{12,18, 19, 20, 21}. There is substantial evidence that memories of traumatic events are not ‘locked in the brain’ in a state of ‘neurological stasis’ but are as malleable as memories for non-traumatic events^{12, 19, 22, 21}. Secondly, the theoretical justification of the eye movement (or ‘bilateral stimulation’) component is unclear¹². Whilst Shapiro offers a neurobiological rationale for this component²³, other authors argue that this explanation approaches “the limits of neurobabble”¹³.

In conclusion there is no evidence that EMDR is a unique or effective treatment. It is not clear why it was endorsed by NICE, but it may be because the comparative studies they reviewed appear, at first glance, to suggest that EMDR produces clinical outcomes that are, at the very least, no worse than those obtained using other interventions. However, a closer look at dismantling studies reveals that only the desensitization component (D) appears to be active, whilst the novel eye movement (EM) and reprocessing (R) components appear to be inert and lack a coherent theoretical underpinning. Given that the only active component of EMDR is already part of successful interventions for PTSD (e.g. CBT) it would seem more appropriate to focus research and training resources on improving these established interventions, rather than on EMDR—the effectiveness of which has yet to be convincingly demonstrated.

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No competing interest declared.

Dr James Ost is on the Scientific and Professional Advisory Board for the British False Memory Society (BFMS), a registered charity that serves people and professionals involved in contested cases of abuse. The BFMS website can be found on www.bfms.org.uk

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INTEGRATED HEALTHCARE: CLUB CLASS OR ECONOMY?



John Garrow, chairman of HealthWatch, reports on “Integrated Health: coming of age?”, the recent two-day meeting at the Royal Society of Medicine which was sponsored by the Prince of Wales’s government-funded Foundation for Integrated Health

IN THE DAYS of old, several centuries ago, healthcare was delivered at shrines where relics of saints were believed to have healing powers. Devout and ascetic monks and nuns comforted those affected by the plagues that recurred in cities. They gave the sick the last rites, and buried them in consecrated ground. It seems the recipients of this care were grateful, since they expected to benefit after their resurrection. In rural areas care of body and soul was shared by the local doctor and priest. The doctor was a respected figure: educated, caring, and willing to ride out into the night to administer herbal remedies to anxious peasants.

Today, in the UK, there is little satisfaction with the NHS, although the level of healthcare delivered is generally very good. Doctors are employees of the taxpayer, highly trained at great expense. They are neither devout nor ascetic, and they frequently fail to achieve the targets set by their managers in Whitehall—for example they sometimes fail to detect cancers that (in retrospect) were detectable on screening tests. They do not ride out into the night (or day) to comfort the sick, but shelter behind inadequate deputising services. They do not understand the patient’s mind, and do not believe he has a soul. The only shrine at which they worship is that of the all-powerful pharmaceutical industry. They are inhumane prescribers of powerful and expensive drugs, and they try to conceal the damage that these drugs often do.

Given this scenario (or caricature, depending on your view of modern medicine) it must be a good idea to “harness all the medical knowledge and skills available—not just from orthodox medicine...but also from other traditions” as Prince Charles’ Foundation for Integrated Health (FIH) suggests. What? Surely not all the other traditions! For example, some of the “alternative” therapies listed in the FIH’s “Guide for patients”¹ strain credulity even more than the alleged healing power of saintly relics. Hands up those who really believe that practitioners of Craniosacral therapy can by “very light touch to the body” detect and correct “imbalances and restrictions in the flow of cerebrospinal fluid” which cause “physical, mental, emotional or psychological injuries and tensions anywhere in the body.” (see p 33 of the Guide). I find it much more difficult to believe in that nonsense than in the healing power of a pilgrimage to a magnificent mediaeval cathedral to touch the (alleged) toe of a saint. For these reasons HealthWatch has been highly sceptical of the value of integrating complementary and alternative medicine (CAM) into the evidence-based, tax-payer-funded NHS, while allowing that many people derive important comfort from privately funded CAM, and should be allowed to do so.

“there was the valuable observation that patients with Chronic Fatigue Syndrome (known as CFS, or ME) have a worse prognosis if their diagnosis is ME than if it is CFS”

With this background I was very keen to attend a two-day meeting at the Royal Society of Medicine sponsored by FIH and entitled “Integrated Health: coming of age”². The registration fee (even when reduced for Fellows of the RSM) was a hefty £150, but the administration kindly gave me a free Press pass on the understanding that I would report the meeting, as I am now doing. The RSM is a pillar of the medical establishment, and usually takes seriously the need for evidence of efficacy. How would they handle the unbelievable aspects of CAM, such as Craniosacral

therapy, or even the vastly popular (and royally endorsed) homoeopathy? I should have guessed the answer to that: during the whole two days there was no discussion of the inverse relation of concentration to efficacy in homoeopathy, meridians of vital energy flow in acupuncture, yin and yang, or the reflex points on the soles of the feet beloved by reflexologists. The programme concentrated on the contribution of CAM to pain relief, to quality of life among cancer patients, and to chronic conditions with a large psychological component such as irritable bowel syndrome or chronic fatigue syndrome.

THE PRESENTERS were allowed a maximum of 20 minutes each, with time for about five questions from the audience after each session of 3–4 papers. Each session usually opened with an orthodox clinician describing normal NHS treatment for the condition, followed by reports on the contribution made by CAM procedures. For example, the first session was on back pain: the first paper was on spinal surgery by a NHS orthopaedic surgeon, followed by papers on patients treated with osteopathy, physiotherapy (with acupuncture), chiropractic, and another on a controlled trial of acupuncture alone. I was interested in comparisons between osteopathy and chiropractic (both involve manipulation of the spine) and learned that there is in fact very little difference. I was also interested because the current issue of *FACTS*³ has an editorial by Edzard Ernst reporting that the Cochrane review of 39 trials of chiropractic “have failed to show it is superior to other standard treatments for patients with acute or chronic low back pain”. He also noted a report that cervical manipulation “is the number one reason for people suffering stroke under the age of 45”. Professor Alan Breen, who presented the chiropractic paper, asserted that the procedure was safe, and that 95% of cases of back pain have no organic origin, so success depends greatly on management of psychological aspects.

The most valuable message I gained from the second session was the observation by Professor Peter White (Psychological Medicine, St Bartholomew’s Hospital) that patients with chronic fatigue syndrome (CFS, or ME) have a worse prognosis if the diagnosis they are given is ME than if it is CFS. He concludes that chronic fatigue implies a physiological state that the patient may overcome by suitable exercises, whereas ME implies a viral disease of the brain and muscles over which the patient has no control.

The sessions on the Tuesday afternoon were on quality of life in cancer patients, and it was here that my enthusiasm for CAM rose to a maximum, partly because evidence was presented that the CAM treatments under discussion (herbal medicine, spirituality, aromatherapy, touch therapies) did actually enhance the well-being of hospice patients, but even more because at least two of the speakers (Dr Michelle Kohn of Macmillan Cancer Relief, and Mr Peter Mackereth of the Christie Hospital) were so charismatic that

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Sun dangers: no change in official advice

Jill Meara FFPH, Deputy Director/Public Health Physician HPA-RPD, writes to correct a point made in the article by Oliver Gillie which appeared in HealthWatch Newsletter issue 57 (April 2005).

Dear Sirs

THE RADIATION Protection Division of the Health Protection Agency (HPA-RPD, formerly the National Radiological Protection Board—NRPB) would like to correct a statement made by Oliver Gillie in his article on the health effects of ultraviolet radiation "Charity puts lives at risk". HPA-RPD has

not withdrawn or made any changes to the advice following from the report of the independent Advisory Group on Non-ionising Radiation (AGNIR) cited as reference (7) by Gillie. The HPA and Cancer Research UK SunSmart campaign remains based on the scientific evidence reviewed by that 2002 report.

Yours truly,
JILL MEARA

Reference

Documents of the NRPB: Volume 13, No. 1 2002. Health Effects from Ultraviolet Radiation: Report of an Advisory Group on Non-ionising Radiation.

Oliver Gillie replies:

I TOOK a change of view of the former chairman of the Advisory Group on Non-Ionising Radiation (AGNIR), who was chairman when the report in question was published, to be a change in the view of NRPB.

In my report "Sunlight Robbery", I have challenged the NRPB evidence, such as it is, purporting to show that casual exposure of hands and face to the sun in the UK provides sufficient vitamin D for good health and have not yet had an answer to that challenge from Jill Meara or anyone else. I

very much hope that the Health Protection Agency will now spell out the scientific basis for their sunlight recommendations including experimental evidence for the policy or at least calculations of the vitamin D that might be obtained from casual exposure of hands and face at UK altitudes and in our maritime climate. This important subject can then be fully discussed in scientific terms.

Yours,
OLIVER GILLIE

Integrated Healthcare: Club class or Economy? by John Garrow ...continued from page 6

I hope every hospice has similarly inspiring people on the staff. It is obvious that any terminally ill patient, for whom conventional medicine has nothing more to offer, must benefit from the attention of a carer who cares, who is optimistic, who treats you with respect and offers you choices about your management, even if the benefit is difficult to demonstrate under the rather impersonal conditions of a randomised controlled trial.

The second day of the meeting was about management of chronic pain, and the regulation of CAM practices and practitioners. It opened with a presentation by Dr John Scadding about the neurobiology of chronic pain. Modern techniques (especially PET scanning of the brain) show the inadequacy of the idea that pain is something that the brain registers when a noxious stimulus is detected at a sensory nerve ending. The same stimulus may produce vastly different sensations depending on many neural loops that may intensify, inhibit or alter the response, and the response to the first stimulus may modify the response when that stimulus is repeated. In short, the management of chronic pain is very difficult and unpredictable, but also very important, since disability and unemployment are a huge burden on public resources. It is not surprising, therefore, that effective treatments are more likely to be found in multidisciplinary pain clinics than unimodal clinics.

THE SESSION on regulation of CAM was strong on "promising developments" and weak on actual achievements. Accreditation would (of course) be reserved for therapists, and therapists, that are shown to be effective, but there is no consensus about how efficacy should be demonstrated. "Not different from placebo" does not demonstrate inefficacy if both the treatment and the placebo are better than no treatment at all. Some treatments are effective in the hands of charismatic practitioners but not when administered by those less gifted. Sir Iain Chalmers castigated everyone (CAM or orthodox) for not informing themselves adequately about previous research, or considering the pos-

sibility that their treatment does more harm than good. Ah me!

So did the meeting convert me to support CAM integrated into the NHS? It sometimes does good, doesn't it? Yes, it sometimes does good, and its success highlights the major weakness of the NHS. The scenario (or caricature) in the second paragraph of this report has some truth in it: NHS medicine is dominated by ruthless pharmaceutical interests, and needs an injection of more ruth (defined by the Oxford English Dictionary as "pity, compassion"). It might get it by incorporating more CAM, especially in pain control and care of terminal illness, but would do so at a cost. I am struck with a similarity between the problems of the NHS and long-haul airlines. Both are subject to severe cost restraints. Airlines offer club class, with privileged check-in and boarding arrangements, more legroom, better food and drink etc. for those willing and able to pay higher fares. No doubt it could be shown that club class passengers arrive in better shape than those in economy class. As long as CAM is added to, and not substituted for, conventional best medical care, it is the healthcare equivalent of club class: it gets you to the same destination at the same time and with the same safety, but in greater comfort. Airlines do not provide club class service to all their passengers (although the passengers would like them to) because it costs too much. Can the NHS afford to fly club class?

John Garrow
Emeritus Professor of Human Nutrition
University of London

References

1. *Complementary Health Care: a guide for patients* is available from the Foundation for Integrated Health web site <http://www.fihealth.org.uk>
2. Conference report can be found on the FIH website on http://www.fihealth.org.uk/fs_conferences.html
3. Ernst, E. The value of chiropractic. *Focus on Complementary and Alternative Medicine* 2005; **10**: 87. Can be viewed on <http://journals.medicinescomplete.com/journals/fact/current/fact1002a02t01.htm>

HEALTHWATCH AND CAM: ALLIES OR ENEMIES?

This is an edited version of a presentation by Professor John Garrow, HealthWatch's chairman, at the British Dietetic Association's Annual Conference in Cardiff on 16th June 2005. A fuller version including bibliographic references will shortly be available at www.HealthWatch-uk.org

BOTH HEALTHWATCH and practitioners of Complementary and Alternative Medicine (CAM) wish to improve the standard of healthcare in the UK, so they might be expected to regard each other as allies. This is not always the case. Some CAM practitioners regard HealthWatch as a subversive organisation (possibly supported by the pharmaceutical industry) that seeks to discredit CAM and to promote "allopathic" remedies.

Readers of the *HealthWatch Newsletter*, or those who inspect our annual accounts, will know this charge is not true: we are not supported by the pharmaceutical industry, nor are we specifically hostile to CAM, but we are opposed to therapeutic claims by any practitioner (orthodox or CAM) that are not supported by good evidence that they are effective.

HealthWatch and CAM practitioners have different ideas about what represents "good evidence". Our criteria of good evidence are set out in the Position Paper on Clinical Trial Design (available from our website). Efficacy should be demonstrated by randomised controlled trials (RCT) that show greater benefit in a group receiving the treatment than in the control group who do not receive the treatment. However, the "Guide for Patients" produced recently by the Foundation for Integrated Health (FIH) commends 16 complementary therapies which are "most widely used", and neglects the issue of efficacy. The FIH's argument is that if many people use (and usually pay for) a complementary therapy they must find that therapy helpful, and if they find it helpful that is the essential test of efficacy. But the kind of "anecdotal" evidence that attracts patients to CAM can be very misleading, as the following stories demonstrate.

In 1945 Sister Kenny came from Australia to Stanmore Hospital in north London to demonstrate her new treatment for patients paralysed by poliomyelitis. She put warm towels on wasted muscle, which certainly seemed to improve their rate of recovery. However, when she moved on from Stanmore the application of warm towels ceased to have any effect on paralysed muscles. Careful investigation revealed that when she was at Stanmore her enthusiasm encouraged patients to exercise the paralysed muscle to the maximum of its capacity, and it was this enhanced exercise that accounted for the improvement. It was better physiotherapy, not the warm towels that benefited the patients.

In 1988 a GP in North London used "applied kinesiology" to

detect food allergy. The patient held a glass tube containing a suspected allergic food extract in one hand, and the test was deemed positive if there was diminished muscle power in the opposite arm. The GP used the test to make many diagnoses of allergy to a wide variety of food extracts. He also observed that patients who subsequently avoided these foods enjoyed better health. So confident was he that the test was valid that he agreed to a "blind" check on positive results. This showed that there was no correspondence between the response obtained with the allergen labelled (eg. "egg") and the response obtained with an identical tube which was labelled only with a code letter.

Anecdotes may suggest that CAM therapies are effective, but RCT can prove it. In the US there are several large RCTs in progress to test the efficacy of CAM therapies, but not in the UK. In 2000 the House of Lords Select Committee (HLSC) advised that publicly funded research should determine the efficacy and safety of major CAM therapies, but ultimately the money was not applied to this key question, but instead was used to sponsor other CAM projects. Meanwhile untested CAM therapies are promoted to the public by some journalists, and by pressure groups such as FIH.

HealthWatch is for treatment that works. We regard as allies those (e.g. the GP kinesiologist, Dr George Lewith, Prof Edzard Ernst, HLSC) who support the proper testing of CAM treatments, just as conventional treatments are tested. But we are against those (e.g. Susan Clark, FIH) who promote CAM treatments for which we have not seen good evidence of safety and/or efficacy.

State Registered Dietitians are trained to provide evidence-based treatment. I urge them to join with HealthWatch to protect NHS patients from therapies that are based on anecdotal evidence, and to try by controlled trials to identify those components of CAM that actually benefit patients.

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1. The assessment and testing of treatments, whether "orthodox" or "alternative";
2. Consumer protection of all forms of health care, both by thorough testing of all products and procedures, and better regulation of all practitioners;
3. Better understanding by the public and the media that valid clinical trials are the best way of ensuring protection.

HealthWatch welcomes membership enquiries from those who share its aims. Membership costs £16.00 per year (£10.00 for students; £20.00 for those outside Europe). Questions about membership can be sent direct to Shirley Churchman at shirleychurchman@btopenworld.com

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