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Newsletter 64 January 2007

AWARDS FOR BAD AND GOOD SCIENCE

DR BEN GOLDACRE, writer of the Guardian's weekly "Bad Science" column, received the 2006 HealthWatch Award at October's Annual General Meeting. He is seen here, below and far right, with president Nick Ross after his entertaining presentation titled, "Bad Science: from the classroom to the front page". Read the Chairman's report on page 3.



Janet Richards, left, of Fishguard was a runner-up in the HealthWatch student prize for evaluation of clinical research protocols. Miss Richards, 28, a student nurse from Swansea University's School of Health Science, said, "The skills I picked up in my lectures stuck in my mind." She was present at the HealthWatch Annual General Meeting to collect her £100 prize from HealthWatch president Nick Ross. The first prize was won by Emma Court, a medical student from Barts and The London Queen Mary's School of Medicine and Dentistry. The prize is generously supported by a grant from the Ajahma Trust.



and...NOT the HealthWatch Award

THE AGENCY behind the 2005 Smallwood report has also won an award, though not from HealthWatch. Fresh Minds, which was commissioned by economist Christopher Smallwood to support Prince Charles' case for promoting the use of unproven medicines in the NHS, was officially joint Best Agency in the 2006 Research Excellence and Effectiveness Awards. It was cited for its strong increase in revenue and new business, its integrity, excellence, collaboration and, well, freshness.

Since it was Fresh Minds that conducted the Smallwood research, I was interested to find out more about this winning team. Now call me naïve but I had rather assumed that research into critical issues of life, death and suffering through disease or injury would be conducted by people with an independent frame of mind and with great scientific rigour. But it turns out that Fresh Minds is a market research company. It doesn't do medical research, it does brand awareness, product and concept testing, customer and employer satisfaction, and its tools are phone and email surveys, focus groups, "teledeth" interviews and the like. It is about selling products and public relations; indeed the agency boasts: "We can put together a team to deliver the results you need".

Now I have no quarrel with this. I could do with a bit of good PR

myself. Fresh Minds grabbed a new business opportunity and, true to their promise, Prince Charles got the results he wanted. I'm just a little disappointed with Christopher Smallwood. There are many good economists, and some of them are truly scientific in the way they approach their task of amassing and evaluating complex data. But in commissioning Fresh Minds Mr Smallwood plainly preferred to gauge opinion rather than measure clinical outcomes.

Well, again perhaps I'm naïve, but I had always thought that clinical outcomes were what medicine was for. And as the famously sceptical Prof Richard Dawkins put it: "Either it is true that a medicine works or it isn't. It cannot be false in the ordinary sense but true in some 'alternative' sense." Never mind. It can still buy good PR.

Nick Ross, President of HealthWatch

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RISE IN NUMBER OF USELESS OR HARMFUL NEW DRUGS

THE PROPORTION of new drugs that have no therapeutic benefit has increased dramatically over the last two decades, says research presented at Health Action International's 25th Anniversary conference in Amsterdam. Despite recent innovations in drugs such as antibiotics, corticosteroids, diuretics and contraceptives, a global analysis of 3,335 new drugs dossiers over 25 years found that a little over 2% of new drugs have brought a real advance for patients, while 69% have brought no advance at all.

Even more worryingly, the percentage of new drugs arriving on the market with a negative benefit-harm ratio has grown 22-fold in the last fifteen years, said Danielle Bardelay, co-editor of the French journal *La Revue Prescrire*. She blamed the situation on lack of transparency from drug companies. "Evidence based health care cannot be envisaged when evidence is hidden," she suggested. "Access to evidence enables us to distinguish between drugs which contribute to therapeutic advance and those which are useless or even dangerous." But, she added, "The competition among pharmaceutical companies is now so violent that one cannot expect transparency from companies."

The barrier to transparency, says HAI, is an over-broad definition of "commercial confidentiality" which, it is argued, should be explicitly limited to information that is unrelated to a product's safety and effectiveness.

Reports of laboratory, animal and clinical studies submitted to the European Medicines Agency (EMA) to establish a medicine's safety and effectiveness for market authorisation are not yet publicly available. HAI Europe argues that access to such data is a pre-

requisite to public health and trustworthy communication.

"If only partial scientific information is made public, prescribing and drug use decisions will be misinformed, not adequately informed. We know from recent experience that these misinformed decisions have serious consequences: for example, thousands of heart attacks and deaths from rofecoxib (Vioxx) use might have been prevented had there been full public access both to pre-market data on rofecoxib's cardiac adverse effects and to full data on outcomes of the VIGOR trial", said Barbara Mintzes of HAI Europe, who are calling for the adoption of a precise and limited definition of commercial confidentiality and regulatory procedures that make transparency the norm and secrecy the exception.

Danielle Bardelay spoke at the 25th Anniversary Conference of HAI Europe, "Pills, Potions and Practice". Health Action International (HAI) is an independent, global network of over 200 consumer, health, development and other public interest groups involved in health and pharmaceutical issues, that works to increase access to essential medicines and improve their rational use.

More information is available on www.haiweb.org

Patient choice agenda ignores cost to taxpayer

THE GOVERNMENT'S patient choice agenda ignores the necessity for rational spending, said a recent editorial in the *Lancet*, which called upon the UK Government to show vocal support for the National Institute for Health and Clinical Excellence (NICE) as the best mechanism to ensure equity in the country's health system. (The editorial raises arguments enlarged upon in an article by John Garrow on page 5 of this issue.)

"By urging patients to demand more from health services, the government is effectively ignoring the fact that a taxbased system means some kind of rationing is essential," said the editorial. It referred to the public outcry that followed recent NICE guidance restricting the

use of four drugs for Alzheimer's disease. Accusations from patient groups of "blatant cost-cutting" are evidence, says the *Lancet*, of the gulf between patient expectations of the health system, and understanding about the necessity for rational spending. Yet NICE's recommendations are necessary to make best use of limited funds in the UK's tax-funded health system, the *Lancet* believes. "If the government really wants to extend choice within the NHS, as it has pledged, it should launch a debate about the health-financing framework necessary to support this philosophy."

Lancet 2006; **368 (9545)**: 1394.

news in brief

ANOTHER STUDY, this time from the *American Journal of Clinical Nutrition*, adds to the evidence that antioxidant or B vitamin supplements are not as healthy as commonly believed. New meta-analyses of trials using antioxidants (vitamins E and C, beta-carotene or selenium) and trials using B vitamins (folic acid, vitamin B6 or vitamin B12) in which the progress of atherosclerosis (arterial disease) was measured by imaging techniques such as ultrasound and angiography, could find no evidence of a protective effect of any of these supplements on the progression of atherosclerosis. The authors suggest that this helps explain their lack of effect on clinical cardiovascular events.

American Journal of Clinical Nutrition 2006; **84**: 880-887.

VITAMIN D, on the other hand, may help curb breast cancer progression, suggests a small study published in the *Journal of Clinical Pathology*. Amongst 279 women with invasive breast cancer at various stages, Cancer Research UK scientists found that women with early stage disease had significantly higher vitamin D levels than did the women with advanced disease. Low levels of vitamin D may promote progression to advanced disease, venture the authors. There is epidemiological evidence of a link between

rates of, and deaths from, breast cancer and exposure to sunlight (vitamin D is produced by the effect of sunlight on the skin).

Online First J Clin Pathol 2006; doi:10.1136/jcp.2006.042747

View paper at: <http://press.psprings.co.uk/jcp/october/cp42747.pdf>

ALTERNATIVE THERAPIES used as primary treatment for breast cancer are associated with increased rates of recurrence and death, say scientists writing in the *American Journal of Surgery*. They reviewed 33 breast cancer patients who refused or delayed orthodox treatments in the form of surgery, chemotherapy or radiation therapy, in favour of alternative treatments. Prognoses were calculated for each patient based on their prospects with the recommended orthodox therapy and after the actual therapy received. Of 11 patients who initially refused surgery, 10 developed disease progression. Of 10 patients refusing local control procedures, two developed local recurrences and two died of metastatic disease. By refusing chemotherapy, nine patients increased their estimated 10-year mortality rate from 17% to 25%. Homeopathy used instead of surgery resulted in disease progression in most patients.

American Journal of Surgery 2006; **192**: 471-473.

WE ARE STILL NEEDED



HealthWatch Chairman David Bender summed up an eventful year at the Annual General Meeting on 18th October 2006

IT WOULD be nice to think that HealthWatch has achieved its aims and we are no longer needed. However, a quick review of the past year shows that we are still needed as much as ever, if not more. In March 2006 the NHS Prescription Pricing Authority ruled that a magnetic leg wrap could be made available for prescription by GPs to treat arthritis, swollen ankles, period pains and varicose ulcers. This was despite an editorial in the *British Medical Journal* stating that “patients should be advised that magnet therapy has no proven benefits”¹.

The Smallwood report commissioned by HRH the Prince of Wales suggested that £48 million could be saved if 10% of GPs offered homeopathy as an alternative to standard drugs, and that 42% of GPs in England would consider referring patents to a homoeopath². However the evidence suggests that this would not be effective. In December 2005 the *Lancet* published a review of 110 randomised controlled trials of homeopathy and concluded that they were not any better than placebo³.

In January 2006 Lord Taverne asked in the House of Lords whether HMG “have any proposals to withdraw NHS funding for homeopathy”. The response from the Secretary of State was that “Decisions on the commissioning of complementary and alternative therapies, including homeopathy, on the NHS are matters for primary care trusts. The Government consider that clinical decisions on the use of complementary or alternative treatments should be left to clinicians. However there is scope for NICE to include assessment of complementary therapies in its guideline work”⁴.

Undeterred, HRH the Prince of Wales addressed the World Health Organisation in May 2006 to ask doctors to embrace alternative therapies in the fight against serious disease. This led 13 distinguished scientists, with support from the Royal Society and the Royal College of GPs, to write to NHS Trusts urging them to stop funding [unproven or disproved] alternative therapies. Reporting this, Dominic Lawson writing in *The Independent* asked, “Can you tell the difference between homeopaths and witch doctors?”, and answered his own question by saying, “Witch doctors are not publicly funded within the NHS”⁵.

As reported in the last *HealthWatch Newsletter* (issue 63, October 2006), from September 1st in the UK homeopathic remedies will be allowed to describe the illnesses they claim to be able to treat, under the National Rules System introduced by the MHRA. This is supposed to be to bring homeopathic remedies into line with licensed medicines. However, homeopathic remedies will not require evidence from clinical trials; they will simply “have to comply with recognised standards of quality, safety and patient information” and the manufacturers need only show that the product has been used to treat those particular conditions within the homeopathic industry. This led Michael Baum to say, “This is like licensing a witches’ brew as a medicine so long as the bat wings are sterile”⁶.

Perhaps the statement made by HRH the Prince of Wales when launching the Smallwood report was closer to the truth than he intended when he said, “I can’t tell you how pleased and proud I am that so many eminent and sensible quacks are joining with my Foundation”⁷.

Although HealthWatch is a small organisation, people are obviously interested in what we have to say. The website now attracts between 40 - 50,000 hits a month; in August 2006 13,700 were direct requests (that is, people had bookmarked <http://www.health-watch-uk.org>, and gone directly to it), while Google and other search engines were responsible for another 2250. Wikipedia yielded 59 hits and an unexpected (and inexplicable) 951 came from the University of California Davis Sustainable Agriculture Program. The majority of these came from people with a .com or similar generic internet connection, but 4345 were from known UK

addresses, and another 11,000 from countries as far apart as New Zealand, Ghana, Malaysia, Canada and various European countries.

Country	no of hits	country	no of hits
UK	4345	Hungary	145
Australia	893	Mexico	127
Canada	638	Portugal	115
Netherlands	571	Poland	103
Germany	493	Japan	98
France	478	India	69
New Zealand	328	Greece	64
US educational	234	Brazil	60
Ireland	211	United Arab Emirates	55
Turkey	208	Austria	50
Malaysia	170	Finland	49
Switzerland	156	Belgium	43
Singapore	152	Ghana	42

Any chairman is only as good as the committee members who keep the organisation running. I am especially grateful to the Secretary Michael Allen, and his wife Walli Bounds, who really run the committee, and make sure I know what is going on; to Anne Raikes, the treasurer, who handles all sorts of boring legal things to do with the Charity Commission, as well as keeping our finances in order; to John Garrow, the Vice-Chairman, who also takes on a great many tasks that I and others should have done. Shirley Churchman has been Membership Secretary for some years now, and sadly she is standing down at this AGM; we have yet to identify a replacement for her. Heinz Wolff resigned from the committee in the summer because of the pressure of other commitments, and as from this AGM Vincent Marks (a founder member of HealthWatch) is also retiring. The other members of the committee all make valuable contributions: Diana and Malcolm Brahams (and we are especially grateful to Malcolm for the occasional solicitor's letter on our behalf), Elizabeth Fairfax (a previous winner of the Ajahma Trust-sponsored Student Prize), Neville Goodman, John Illman, Keith Isaacson and Gillian Robinson. Three other people, who are not members of the committee, are indispensable: Mandy Payne, who edits the Newsletter (and somehow makes sure there is always enough interesting material to fill the pages); Caroline Addy, who checks the Newsletter before publication for possibly libellous statements; and Joan Gandy, who undertakes all the administrative work for the student prize.

David Bender
HealthWatch Chairman

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2. *Guardian* 26th August 2005.
3. *Lancet* 2005; **366**: 726-32.
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5. *Independent* 26th May 2006.
6. *Guardian* 1st September 2006.
7. *Guardian* 13th October 2005.

TRANSGRESSING THE BOUNDARIES



Edzard Ernst is the UK's only professor of complementary medicine. He has published more than 30 books and over 700 articles in the peer-reviewed medical literature. Last year he added the HealthWatch Award to his many scientific prizes. Here he laments the influence of post-modernist thinking on research into complementary medicine

ALAN SOKAL, a physicist from New York is perhaps best known for publishing a paper entitled, "Transgressing the boundaries: towards a transformative hermeneutics of quantum gravity"¹. Unbeknown to the editors of the journal, this paper was full of deliberate absurdities which were meant to make fun at post-modernism and to ridicule its attacks on science.

After this paper was published, Sokal disclosed it as a hoax. One would think that this was the end of post-modernist anti-science. But that would be wishful thinking. In complementary/alternative medicine (CAM), I see the influence of post-modernism regularly.

The main contention of post-modernism is that science's claim to objectivity is wrong: there is not a single truth but many, equally valid truths. It follows (for post-modernists) that there is not one way of knowing, but many. There is no such a thing as a natural law, only man-made constructs. The discoveries of scientific medicine are on equal footing with those of Traditional Chinese Medicine. The Krebs cycle has the same validity as the concept of Yin and Yang. Evidence-based medicine is a political ploy of the "establishment" to stay in power.

Perhaps you think I am exaggerating. But I don't think I am. Consider the following quotes from the recent CAM literature:

- [CAM poses] a threat to the long-standing hegemony in the West².
- There is no such thing as The Evidence, just competing bodies of evidence³.
- Scientifically constructed evidence for an alternative therapy only works when the therapy has mutated into a medicalised version and divested itself of its alternative philosophy².
- Evidence-based medicine is driven by those with managerial rather than clinical backgrounds³.
- RCT methodology...[ignores] subtle complex effects².
- Healing... [works] primarily through providing a meaning to its participants².
- The narrowness of science has become apparent, so full of fact and empty of meaning³.
- Orthodox medicine should consider abandoning demands that CAM become evidence-based... but insist instead upon a more complete and coherent description and defence of the alternative epistemic methods and tools of these disciplines⁴.
- [Evidence-based medicine is a] hegenomic cultural movement generated as a continuation of the ascendancy of medical dominance⁵.
- [Holism embraces] concepts of psychosomatism, consciousness and energy⁶.
- The round problems of CAM [do not fit] into the square holes of the scientific method⁷.
- A full analysis [of CAM] represents a level of complexity that tends to overwhelm its [science's] methodology⁸.
- Knowledge of RCTs would be of little use in therapeutic practice⁵.
- The evidence-based movement in health sciences constitutes a good example of microfascism... [This is] more pernicious [than the] fascism of the masses, as was practised by Hitler and Mussollini⁹.

The attentive reader will have noticed two things. The last text (9) is not related to CAM but to evidence-based medicine. I have cited reference 2 more frequently than any other. This article is remarkable in several ways. Its author, Christine Ann Barry is affiliated or a member of the School of Science and Law, Brunel University. She

provides the following footnote on the front page of her paper: "The Department of Health National Co-ordinating Centre for Research Capacity Development supported me during the writing of this paper". This begs the question whether it is the remit of research capacity development to finance such work. I wanted to find out and wrote to them. Sadly, I did not receive a reply.

"It follows, for post-modernists, that the Krebs Cycle has the same validity as the concept of Yin and Yang"

I have struggled long and hard with post-modernism in CAM. The often rather obscure phraseology of the post-modernist-inspired authors has made this endeavour not easy. Eventually I came to the conclusion that post-modernists do accept science. They use a car, travel by aeroplane, watch television, have surgery, take antibiotics etc. But they accept science only when it suits them, not as a matter of principle. When the results of scientific investigations do not fit into their preconceived ideas, they reject science. A friend of mine has criticized this "cherry picking" succinctly: if it looks like bullshit, smells like bullshit and behaves like bullshit, it probably is bullshit. But I, of course, cannot say such things - it would mean transgressing boundaries.

Edzard Ernst
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PATIENT-CENTRED MEDICINE (PCM):

a very personal view



ON THE 30TH SEPTEMBER 1994 my life changed abruptly. Every month for the previous forty-two years my employers, either a University or the Medical Research Council, had paid an ever-increasing sum into my bank account. In return I was required to provide healthcare for patients who had clinical problems within my field of competence, to conduct research to try to make this healthcare more effective, and to contribute to the education of some medical students. Now all that has stopped.

I was then 65 years old, retired, and no longer a healthcare provider¹ but instead a Patient, and predictably an ever more demanding consumer of the healthcare provided for me by the NHS.

When I was a healthcare provider I had a clear idea of my duties but what are my duties as a Patient? This is a topic on which there is conflicting advice. In 1995 there was a document called a "Patients' Charter". This contained statements about how conscientious and courteous the healthcare providers promise to be, and how they hope patients will reciprocate and provide constructive criticism where the service does not come up to their expectations. Fair enough, but now we are urged to seek the much more radical concept of Patient Centred Medicine (PCM). This is explained in some detail in the *British Medical Journal*^{2,3} and the website <http://www.trainer.org.uk/members/theory/curriculum/patient-centred.htm>⁴

In her editorial about PCM Stewart² states: "Patients want patient centred care which (a) explores the patients' main reason for the visit, concerns, and need for information; (b) seeks an integrated understanding of the patients' world that is, their whole person, emotional needs, and life issues; (c) finds common ground on what the problem is and mutually agrees on management; (d) enhances prevention and health promotion; and (e) enhances the continuing relationship between the patient and the doctor." The evidence that patients want their GP to do all these things comes from the observational study of Little *et al.*³ They solicited the views of 865 patients in three practices, and interpreted the results as showing that patients rated the patient-centred component of primary care higher than other aspects, such as examination or prescription.

I regard this conclusion with great scepticism. No doubt there are many patients who would like to have a deeper relationship with their GPs, but I believe that even more (including me) would object strongly to the consequences of this policy. In her fuller exposition of PCM Stewart⁴ lists the skills and attitudes required by the GP to enhance the patient-doctor relationship. These would require a level of empathy and self-sacrifice far beyond belief. Stewart does not mention the amount of time that would be required to deploy these qualities in a realistic clinical situation. Tallis⁵ has described the time constraints already existing in both hospital and primary care in the modern NHS. He demonstrates that it is barely possible to obtain from patients "informed consent" for procedures at the level of thoroughness now required by medical administrators. Obtaining consent is a trivial task compared with the relationship-building activities that Stewart proposes. A PCM consultation would take at least 10 times as long as a non-PCM consultation. The study of Little *et al.*³ might have yielded quite different preferences if they had offered the choice of PCM healthcare, but at a cost of 10 times longer waiting to see the doctor.

My strong preference is for Evidence-Based Medicine (EBM) rather than PCM for two reasons. First, when I visit my GP it is to find out about the best eye drops to inhibit glaucoma in one eye, or for advice on the best management of a hip joint that is beginning to feel its age. I do not want an exploration of my main reason for my visit, my concerns, and need for information. Still less do I want an integrated understanding of my world and all that, thank you. But I do want expert evidence-based guidance about my eye, or hip, and I want it quickly. I have little sympathy with the PCM patient ahead of me in the queue who may be building better doctor-patient

relationships with our mutual GP, but who is also wasting half an hour of my time. Second, I see little evidence that the PCM approach actually produces better healthcare, despite the expenditure of much greater resources, except in a minority of patients who need social support rather than medical treatment.

Since I require my healthcare providers to meet EBM standards, of course I have a duty to agree to participate if the practice is engaged in a well-designed and publicly registered randomised trial of treatments for glaucoma or early osteoarthritis. As Evans *et al.*⁶ very clearly explain, co-operation in clinical trials is the only way patients can help to improve health care, so it is in the patients' interests to volunteer to be randomised. However I do not agree that patients should require their GP to provide tutorials on clinical trial design. Information about this is available elsewhere (see Evans *et al.*⁶) for patients who really want to know.

Finally, I worry about the widely accepted view that patients are the best people to decide on allocation of NHS resources. Of course patient support groups for a particular chronic disease are the ultimate experts on the needs of patients with that disease. The problems arise when the case is made that the NHS has "failed" in providing proper support for those afflicted with a particular disorder, and that the scandal of this injustice must now be corrected. This case will, of course, be made by the patients, or sometimes covertly by the drug firms that sell a treatment for this disorder. As Tallis points out, all patients are consumers of resources provided by the taxpayer, and are effectively competing with each other. We are naturally biased in favour of help for the patient group to which we belong, at the expense of patients in different groups.

On re-reading this note I see that all the arguments I have advanced are essentially narrow and self-serving. Perhaps this is a characteristic that is prevalent among my contemporaries. It is even possible that my former employers knew what they were doing on 30th September 1994. They were off-loading me before I became selfish and cantankerous.

John Garrow

Emeritus Professor of Human Nutrition, University of London

References

1. In early life I had implanted in me by my medical parents a prejudice against private practice. They cited as evidence Dr X, a highly successful private practitioner whose clinical competence was questionable, but who, when he retired, was sadly missed by his patients. "When I visited him I could tell that he really minded about my problems," they said. Maybe he did, but I heard that his success was attributable to his invariably lugubrious expression. Even when tucking in to a delicious meal he showed no sign of enjoying himself. I have never done private practice myself.
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NUTRITION NOT THE ANSWER TO EVERYTHING

Food is better medicine than drugs by Patrick Holford and Jerome Burne

Piatkus, London 2006: ISBN 0-7499-2710-0. 464 pages. £16.99

THE AUTHORS of this book attach an unusual meaning to the words “food” and “medicine”. Of course food is essential for our survival - if deprived of food (but not water) the average person will starve to death in about 10 weeks. “Medicine” is normally something you take to help you to prevent, or recover from, an illness. So which food is superior to drugs in the treatment of which illness, and what is the evidence that it is superior?

On page 13 the authors concede that, in the middle decades of the twentieth century, new antibiotics, vaccines, better anaesthetics (and hence better surgical techniques) brought relief, or saved lives, from many diseases. But since that golden era of medical advances they claim that:

“... the performance of drug-based medicine has been far less impressive in preventing and treating the chronic conditions that now plague us - arthritis, depression, diabetes, heart disease. Not only do the drugs concentrate on alleviating the symptoms rather than tackling the underlying cause, but they inevitably have unpleasant and sometimes deadly side effects. And these side effects are made even more damaging by drug companies’ practice of downplaying and concealing them.”

All right then - let us note the former (and continuing) triumphs of drugs in the fight against infectious diseases and trauma, and move on. We are now asked to compare the success of food versus drugs in the treatment of chronic conditions such as arthritis, depression, diabetes and heart disease. In particular, is it true that foods (unlike drugs) are free from side effects? Are proponents of dietary treatments (unlike drug companies) willing to admit the medical disadvantages of food? Which approach to treatment best tackles the underlying causes of these diseases, rather than merely alleviating the symptoms?

“There has not been, and probably never can be, a definitive randomised controlled trial to test this policy’s efficacy in curing or preventing chronic diseases like arthritis, depression, diabetes or heart disease.”

To answer these questions we need to define “food”. If the term includes alcohol and saturated fats then foods certainly do have unpleasant and sometimes deadly side effects. For people with allergies peanuts may have serious side effects. Food (unlike drugs) is often a carrier of pathogenic bacteria, such as salmonella in eggs. I agree that it is true that drug companies (like all commercial concerns) try to present the most favourable aspects of their products, and sometimes they are caught out concealing important hazards, and are severely punished in the courts for the damage they have caused. But it is absurd to accuse the drug firms of concealing side effects since, with every package of a prescription drug, there is a Patient Information Leaflet that lists every known side effect. This is not evidence that drug firms are models of transparency - they do this because by law they are required to do so. Nevertheless, the authors of this book can hardly claim the moral high ground, since they themselves certainly downplay the side effects of food. Indeed they pervert the meaning of the word “food”, by omitting everything undesirable, and incorporating aspects of non-drug lifestyle (such as not smoking, avoiding stress, taking exercise, not hyperventilating, limiting alcohol intake) that cannot reasonably be

included under the heading of “food”.

So much for honesty about side effects - this is a criterion on which neither side scores very high marks. Let us now consider where credit is due for tackling the underlying causes, rather than just the symptoms, of the current chronic diseases that were highlighted by the authors.

The case for dietary treatments begins on p 100: a Chapter entitled “The road to health”, but it does not simply claim that “Food A cures disease X”, but adopts a far more subtle approach. It is suggested that there is a status called “Optimum health” that is attainable by Optimum Nutrition. A person in this state will be protected from chronic diseases such as arthritis, etc. which drugs cannot cure. The six keys to Optimum Health are Blood sugar control, Stable inflammatory response, Neurotransmitters in balance, Super immunity, Hormones in balance, and Good digestion and detoxification. Errors in one area may cause problems in other areas, since they all interact. Defects in these six key areas can be detected by responses to a questionnaire with 160 questions to which there are yes/no answers. Questions to which the answer was ‘Yes’ in over 80% of those sampled are: Do you quickly become impatient? Have bowel movements less than once a day? Have low energy levels? Energy less than it used to be? An array of these positive responses indicates sub-optimal nutrition for which the antidote is a programme usually involving twice daily high strength multivitamins, 1 g vitamin C, and various combinations of omega 3 and/or omega 6 fatty acids, an anti-oxidant formula, and/or mineral supplements.

Is this policy effective? There has not been, and probably never can be, a definitive randomised controlled trial to test its efficacy in curing or preventing chronic diseases like arthritis, depression, diabetes or heart disease. Some large controlled trials have shown that people at high risk (e.g. long-term smokers) taking various anti-oxidant supplements have fared no better, or even fared worse, than controls taking a placebo capsule (for more details see David Bender’s feature in *HealthWatch Newsletter* issue 63, October 2006). The authors dismiss this adverse evidence as bad science fomented by the conspiratorial drug industry.

Concerning the underlying cause of these diseases an obvious candidate is age: these chronic diseases more frequently affect older people as their tissues degenerate or wear out. We are told that our expected life span is three score years and ten, so for those of us over 70 years old the Maker’s warranty has expired. We should not expect either nutrition or drugs to rejuvenate us, but we do know that people who are obese have an older biological age than normal-weight people of the same chronological age, and have a greater liability to develop these degenerative diseases. Of course there is a nutritional regimen that will control obesity, but it involves taking in less dietary energy, not more nutritional supplements.

John Garrow

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WHY MEDICAL JOURNALS MATTER TO US ALL

The trouble with medical journals by Richard Smith

Royal Society of Medicine Press, 2006: ISBN 1-85315-673-0. 256 pages. £19.99 (paperback)

WHY REVIEW a book about medical journals? Richard Smith is the former editor of the *British Medical Journal* and he has written a punchy book that deserves to be widely read. Medical journals are how doctors speak to each other, and how researchers speak to doctors. Thus, if we are to benefit from new treatments, or to be spared from useless and dangerous treatments, medical journals are everybody's business. Discourses around health and disease are as important as the discourses around politics, business and the arts, and this book is written for any reader and not just for people who read medical journals.

Medical journals, says Smith, are probably a force for good but need considerable reform, and he says why and how in typically punchy fashion.

It is enriched by anecdotes, and I was fascinated to read the full story of the St George's Hospital reimplanted ectopic pregnancy story. One of the holy grails of gynaecology is to be able to salvage an ectopic pregnancy by moving the fetus to the womb so that it can continue to develop. Twelve years ago there was a scandal: Malcolm Pearce, a gynaecologist at St George's, had published, along with his professor, a paper that said he had done just that. The paper was fraudulent. The professor was president of the Royal College of Obstetrics and Gynaecology and editor of the *British Journal of Obstetrics and Gynaecology*, where it was published.

"All human life is in this book...there are plagiarists, and there are people in the pay of drug companies"

The book tells how it happened, and alcohol plays a major role in the story. Towards the end of a boozy dinner at the Royal College of Obstetrics and Gynaecology, Pearce told a colleague that he had successfully reimplanted the embryo. The colleague told the media, who contacted Pearce regularly for news, adding to the pressure on him. Over a drink to celebrate the editor's birthday, Pearce told the editorial team about his success, adding that he would like to send a report to the *BMJ* or *Lancet*. The editorial team wanted the report for their own journal and told Pearce they could publish the report in the next issue if he wrote it immediately. Pearce added the professor's name to his paper and the study was rushed into the journal

without the usual process of peer review. There is no suggestion that the professor, Geoffrey Chamberlain (who Smith describes as a Falstaffian figure, and whose nickname was Bodger) was aware of the fraud. However it is astonishing that Chamberlain never asked to see the case notes. A whistleblower at the hospital reported that the patient never existed. Pearce was disgraced, and Chamberlain resigned his post, his editorship, and his headship of the Royal College, and his chances of a knighthood.

There are other examples of fraud, and probably a lot of minor fraud is never unmasked. All human life is in this book, which makes plenty of pertinent points. There are plagiarists, and there are people in the pay of drug companies. Medical journals are difficult to fund, and should they be paid for by authors or by readers or advertisers? What are the pressures on an editor whose journal is financially in the red if he is given a paper of borderline quality (or even of excellent quality) that gives a good report of a new drug, and he knows that the drug company will pay handsomely for a few thousand reprints? Is the process of peer reviewing papers necessary or foolproof (yes and no)? Why is it, for example, that virtually all research on arthritis drugs show that the product under test is as good as or better than rival products?

Richard Smith was asked to write this book by Sandy McCall Smith, professor of medical law in Edinburgh and author of the *No 1 Ladies Detective Agency* books. Cambridge University Press wanted him to take the stories out and make it more academic. He refused. The Royal Society of Medicine Press published it as it stood. It is a gripping read, a real page-turner, and I recommend it.

Caroline Richmond
Medical journalist and HealthWatch committee member

Canada issues "senseless" homeopathy regulations

A Canadian body has issued homeopathic regulations that experts say are "senseless". The news comes from Dr Stephen Barratt MD, who edits the e-newsletter *Consumer Health Digest*. He reports that Health Canada's Natural Health Directorate, whose role is to "ensure that Canadians have ready access to natural health products that are safe, effective, and of high quality," has issued rules for homeopathic products. The development has similarities with the current debate over new rules for the marketing of homeopathic products in the UK (see *HealthWatch Newsletter* issue 63, October 2006 and also page 8 of this issue).

In Canada, products claiming a specific recommended use or purpose need only be suitable for self-care, should not require the supervision of a health care practitioner, and should be supported by "evidence", for which previous marketing experience, expert opinion reports, textbooks, homeopathic provings, homeopathic materia

medica, and homeopathic repertories are sufficient. There is no requirement for clinical evidence, it is enough to "demonstrate a clear rationale for each ingredient". Even products with a non-specific use can be labelled "Homeopathic medicine," "Homeopathic Preparation," "Homeopathic drug," or "Homeopathic remedy."

"These regulations are senseless because no homeopathic product has been proven effective for treating any health problem," says Barratt.

Further information

Evidence for homeopathic medicines, version 2.0. National Health Directorate, November 2006.

<http://www.homeowatch.org/reg/canada.pdf>

Issues of *Consumer Health Digest* are accessible through <http://www.ncahf.org/digest06/index.html>

LORDS DEBATE SPARKS CHALLENGE TO HEWITT

A MOTION to annul new regulations on the licensing of homeopathic products was debated in the House of Lords on 26th October, and has triggered widespread media publicity and a public challenge to the UK Secretary of State for Health.

The Lords debate followed the stealthy introduction in September 2006 of regulations that would give the manufacturers of homeopathic remedies licence to make medical claims for their products without first proving their effectiveness (see *HealthWatch Newsletter* issue 63, October 2006). The charity Sense About Science has been working to promote public debate about the new rules, which came into force without parliamentary time. According to the charity's director Tracey Brown the regulations will permit homeopathic products to make medical claims that, however worded, "imply officially-endorsed efficacy where none has been proven. The Government did not have to change the regulations in this way...At a time when there is, rightly, increasing pressure to take off the market old medicines that do not work, it seems particularly incomprehensible that the licensing regime should lower the evidence bar to include *new* medicines that do not work."

Over 700 people, including many HealthWatch members, protested about the regulations via Sense About Science's website. Two points raised repeatedly were that the restriction of homeopathic labelling indications to minor ailments did not overcome the seriousness of false medical claims (e.g. when one considers the first sign of colonic cancer is usually constipation); secondly, that the Medicines and Healthcare Products Regulatory Agency's stipulation, 'the applicant can establish efficacy...by reference to special investigations called "homeopathic provings"' raised the spectre of serious public confusion about what can be taken as evidence in scientific terms.

ARGUING in the Lords on 26th October in favour of annulling the regulations was Lord Taverne, Sense About Science's chairman and a patron of HealthWatch. He received widespread support from many other scientifically-orientated members. In reply the Minister, Lord Warner, opposed the banning of homeopathic products - a suggestion that no-one had made. After the Lords debate, Tracey Brown wrote to the Secretary of State for Health Patricia Hewitt, circulating her letter to hundreds of supporters.

Brown wrote, "Many scientific and medical bodies are perturbed

that for the first time in its history the regulation of medicines has moved away from science and from clear, meaningful information for the public about whether medicines work... Concerns raised by medical bodies during MLX312* received no attention. (Of 32 responses received, two mistook the consultation for being about herbal medicines, five simply acknowledged receipt, three concerned inclusion of anthroposophic medicines and eight raised serious reservations; but this was described as 'widespread support' in the conclusions)..."

"The mission of the MHRA is to ensure, 'that medicines and medical devices work, and are acceptably safe'. However, with the introduction of the new rules, it now accepts homeopathic 'provings' as evidence of efficacy. A proving is the method that homeopaths use to determine the symptoms a substance causes (with a view to treating diseases with similar symptoms). Proving is not carried out on the finished product and are nothing to do with efficacy."

There is now pressure on the government to reconsider its position on the regulations and to introduce a debate in the House of Commons.

**MLX312 is the MHRA's code number for the consultation on the new National Rules Scheme for Homeopathic Medicines*

For further research

The Sense About Science website can be found on www.senseaboutscience.org and includes links to the many press articles that followed the Lords debate, as well as a two-page briefing document on homeopathy that can be downloaded free:

<http://www.senseaboutscience.org.uk/pdf/SenseAboutHomeopathy.pdf>

The Lords debate can be viewed online at:

<http://www.parliamentlive.tv/Player/index.aspx?Encoding=5521&startat=2006-10-26T13:13:50> and the text can be seen at: <http://www.parliament.the-stationery-office.co.uk/pa/ld199697/ldhansrd/pdvn/lds06/text/61026-0004.htm#06102652000003>

Published by HealthWatch
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HealthWatch promotes:

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 should be sent to: kenneth.bodman@btinternet.com

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