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# HealthWatch

for treatment that works

Newsletter 66 July 2007

## WILL HOMEOPATHY NOW DIE?



**D**ESPITE royal support, homeopathy is having a bad press, writes *Dr Neville Goodman*. Back in 2005, the *Lancet* challenged the Department of Health after a systematic review of placebo-controlled trials<sup>1</sup> found the effects of homeopathy were no more than placebo. Then in 2006, a group of academics wrote a letter to primary care trusts (PCTs) asking them to review their funding of alternative medicine<sup>2</sup>. Now the campaign is gathering speed.

The academics have written again. Concentrating this time on homeopathy, Professor Gustav Born of the William Harvey Institute, and a group of similarly learned colleagues, wrote, “a number of trusts have reduced their provision of homeopathic services through commissioning arrangements to reflect the need for greater scientific scrutiny”, and invited them to review their own trust’s positions<sup>3</sup>. Many of the newspapers picked up on the story. Professor Michael Baum’s well argued critical article in the *Daily Mail*<sup>4</sup> was a welcome change from that newspaper’s usual slant on the medical fringe.

Another of the signatories, Professor Ray Tallis (who has, incidentally, agreed to accept this year’s HealthWatch award), featured in a discussion on the BBC Radio 4 *Today* programme<sup>5</sup> with Dr Peter Fisher. Dr Fisher is the clinical director of the Royal London Homeopathic Hospital, and has been very busy recently defending homeopathy, but I find these “discussions” unsatisfactory. The only way properly to lay out evidence is dispassionately and logically, with proper citation and interpretation. Of course, some evidence - in any walk of life - can be interpreted in more than one way, but it is just too easy for radio discussions to descend into, “Yes it is”; “No it isn’t.”

Published “debates” are often little better. Hospital Doctor’s

recent debate<sup>6</sup>, “Should homeopathy hospital survive?” - was between Dr Fisher (arguing “yes”) and Professor Baum (“no”), but I suspect they were given their briefs in isolation. Dr Fisher mentions homeopathy just once, to say it is only one of a wide range of therapies, whereas Professor Baum focuses on it, so the two sides of the debate talk of different things. However, Dr Fisher appears somewhat ill-informed when he writes of the therapies they offer that, “all are supported by some evidence”. Homeopathy is supported only by selective evidence. Dr Fisher also uses the common ploy of finding reasons why alternative therapies are at a disadvantage. He admits that the level of evidence is not as high as for conventional therapies, but implies that this is only because, “treatments are rarely patentable, and so not of interest to ‘big pharma’”. He writes, “observational outcome studies show clinical improvement and reduction of medication across a wide range of conditions”, but what sort of evidence is that? He cites no references; Professor Baum does.

The *Guardian*’s take on the academics’ letter provoked correspondence<sup>7</sup> from Andrew Kirk, who is the Chairman of the Society of Homeopaths. In it, all the old arguments emerge. “Substantial savings could be made by introducing homeopathy into general practice” true: because too many drugs are prescribed when they are

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## HealthWatch experts publish book on insulin murders

**T**WO FOUNDER members of HealthWatch have published a book of true-life case histories of the use of insulin in murder.

“Insulin Murders - True Life Crimes” is written by Professor Vincent Marks, critically acclaimed author of *Panic Nation* and a world authority on insulin, together with Caroline Richmond, a leading medical journalist. Richmond remains an active member of the HealthWatch Committee, with an article in this issue (page 6), while Marks has only recently retired.

Their book, published by the Royal Society of Medicine, details legal cases over the last 50 years, and offers exclusive access to the medical aspects of the Von Bulow case, the first court case to be broadcast in its entirety on US television, as well as featuring other real life crime cases from the UK to New Zealand. See page 5 of this issue for ordering details and a full review of this fascinating new book.



Caroline Richmond and Vincent Marks at the book launch

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## Does AMA really say adults should take vitamin pills?

**B**UNDLED WITH my *National Trust* magazine in May was a copy of the *Healthspan* magazine and catalogue of nutritional supplements, writes *HealthWatch* Chairman David Bender. On page 22 we are told that, “the American Medical Association recommends that all adults take a multivitamin supplement”. In an article by Sarah Brewer earlier in the magazine<sup>1</sup> we are told a subtly different story; the conclusion of a review of 150 clinical trials was that “pending strong evidence from randomised trials, it appears prudent for all adults to take vitamin supplements”.

In fact, the reference cited was not to the scientific review<sup>2</sup>, but to a three page paper discussing the clinical applications of the literature review<sup>3</sup>.

Fairfield and Fletcher<sup>2</sup> conducted a MedLine search for English language papers about vitamins in relation to chronic diseases published between 1966 and January 2002. Most of these were epidemiological cohort studies showing a relationship between low intakes of various vitamins and coronary heart disease, various cancers and bone mass. Where there have been randomised controlled trials the results have generally been disappointing, as discussed in the *HealthWatch* position paper on vitamin supplements (view updated paper on <http://www.healthwatch-uk.org/Vitamin%20supplements.pdf>), although trials of vitamin D and calcium do show a slowing of bone loss and fractures, and the evidence for a beneficial effect of folate in preventing neural tube defects is very strong.

The patients' page of the same issue of *JAMA*<sup>4</sup> gives an overview of the sources and functions of the vitamins, and states, “The best way to get vitamins is from whole foods - fruits, grains, vegetables, dairy products, and lean meat. However, taking a daily multivitamin supplement will also ensure adequate amounts of the

important vitamins”.

So, the American Medical Association does not recommend that all adults take a multivitamin supplement; a review published in the *Journal of the American Medical Association* suggests that *pending evidence from randomised trials it might be prudent to do so*. The *AMA* advice to patients is clearly that food should be the normal source of vitamins.

David A Bender

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## Will homeopathy now die?

not needed. “The NHS spends £466m a year treating adverse effects from medicines” while, “Homeopathy’s track record for safety is excellent”: true - but unsurprising seeing as it contains no active substance. And is it entirely safe? What of the homeopaths who advocate homeopathy for malarial prophylaxis? The recipients won’t suffer side-effects from the homeopathic preparation but they may well contract malaria.

Andrew Kirk then says that “describing homeopathy as ‘unsupported by evidence’...turns a blind eye to the excellent outcomes from homeopathic treatment”. This “evidence” is an outcome study of 6500 patients, 70% of whom “reported an improvement to their health following homeopathy”, and for many of these patients, “conventional medicines had failed to help”.

I don’t need to explain to readers of this newsletter why this is not very good evidence, but nor do I need to explain how it will be taken, by those who wish to do so, as the perfect counter to anything Ray Tallis or Michael Baum might choose to say. Which is why I would never wish to find myself in a studio with Dr Fisher.

One thing, though, is undeniable. Homeopathic medicines are extremely cheap. In *The Times*<sup>8</sup>, they explained that, with its limited resources, the NHS should only cover treatments properly shown to be effective. Much though I would like to see homeopathy consigned to the medical history books as an interesting hypothesis of its time that died from lack of evidence, I’m afraid it will take the funding of a large number of homeopathic preparations to cover the cost of the expensive new cancer drug that the *Times* chose to feature. In my view, the savings from not allowing homeopathy on the NHS is a secondary consideration to the main one: there is no place for treatment based on nonsense.

Michael Baum was not completely negative, though. He asked that the Royal London Homeopathic Hospital be rebranded as a centre for supportive and palliative care, offering complementary

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therapies that do work, such as psychological counselling, group therapy, therapeutic massage, and music and art therapy. There is a challenge for the medical homeopaths: forget Hahnemann’s outdated notions of infinite dilutions, and concentrate on what they do best, which is achieving rapport with the patients and making them feel better and more able to deal with their problems.

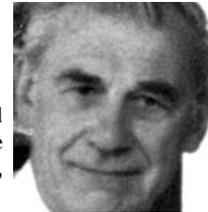
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## CIBeT: CAN IT BE TRUE?



**H**ARDLY any people in the UK have heard of EveRestorer, because it has only recently been advertised writes John Garrow. It is a herbal remedy derived from a lichen which grows at very high altitudes in the Himalayan mountains, mostly on Annapurna, but also on its more famous companion Mount Everest, from which its commercial name has been derived.

It is well known that, in any region of the world where western medical drugs are not readily available, there are natural remedies which are credited with amazing healing powers by the local population. However, unlike ordinary “bush tea” remedies EveRestorer has emerged with impressive evidence that it really is effective, and not merely a placebo. Also, there are plausible theoretical reasons for believing that this product might have unique healing properties. The lichen from which it is derived grows in an extremely hostile environment - the atmospheric pressure is low, there are huge daily fluctuations in temperature (from 35°C in direct sunlight to severely sub-zero temperatures at night), very high rainfall (4 m/year) and (of great interest to molecular biologists) a very high exposure to cosmic radiation.

It has been observed by mountaineers in other regions of the world that vegetation at high altitude was subject to many genetic mutations caused by the cosmic rays which damage the nuclear structure, but this Nepalese lichen seems immune to this damage. Professor MT Klaames, the head of the Nuclear Biology Institute in Pokhara, has just published a review of the clinical trials on EveRestorer, and the evidence linking its therapeutic potency to a novel metabolic cycle that protects the nucleic acids from radiation damage. At a press conference in New Delhi last month he presented this research. When challenged about the evidence for the clinical efficacy of EveRestorer he replied:

*“We have recently surveyed all the placebo-controlled trials with WHO and found about 120 trials. About 50% were clearly positive, a very small number were negative, and quite a few had equivocal results”.*

CIBeT? Assuming that Prof Klaames has correctly reported the total number of published placebo-controlled trials, and the outcome of these trials, does that prove that EveRestorer is effective? Suppose EveRestorer is just the same as the placebo then, by chance, in 120 trials about 60 will show its effect is somewhat better than placebo and in the remainder somewhat worse. Statistically it can be predicted that about 5% (ie. 6 trials) will be, “significantly” better or worse than the identical placebo. So even in a series of 120 trials of placebo A vs. identical placebo B some of the trials will appear to show “significant” superiority of A (or B).

But what if there were really 500 trials, but editors of journals were more willing to publish the results of trials that showed a positive effect than a negative one? This would result in the 120 published trials being biased in favour of positive results.

Remember, these are 120 local trials of a highly-regarded local

remedy versus an inert placebo. Can we be sure that the participants were really “blind” to their treatment allocation? They would be very familiar with the taste, smell, etc. of EveRestorer, so if they correctly guess whether they were on a remedy they trusted, or on a placebo that they knew to be useless, that could affect their response.

Finally, there is a form of bias which, in politics, is known as “spin”. Even scientists at a news conference, presenting their research on a potentially marketable new product, tend to err in the direction of overstating the merits of the product.

I happen to know that the reported efficacy of EveRestorer is not true, because the herbal remedy and Prof Klaames are both inventions by me - they do not exist. But I also know that the passage in italics above is not an invention by me - it is a true record of the response made by a Dr Peter Fisher on the Radio 4 Today programme on 23rd May (for reference, see page 2, ref: 5). He and Professor Raymond Tallis (our 2007 HW Awardee) were debating the rationale for paying NHS money for homeopathic treatments. Professor Tallis had just made the point that there was no good evidence that homeopathy was any better than a placebo, and above I have set out verbatim Dr Fisher’s response.

CIBeT? It is quite likely that Dr Fisher, in association with the World Health Organisation, is collecting evidence about the efficacy of homeopathy - indeed I have heard rumours that such a report exists in draft form, but it is still confidential. Only those who have contributed to it know what the current draft says, and only when it is published will we all be able to see what all the contributors agree on. WHO is in a situation similar to that of the fictional Prof Klaames: there is a need to provide effective remedies in regions (such as western Nepal) where remedies of proven efficacy are too expensive to provide, so placebos (such as homeopathy) must be considered.

When the WHO report is published in full detail it will be possible to compare it with Dr Fisher’s account, and apply the critical tests to see if the conclusions are biased in the manner discussed above. I hope by the time the next issue of the *HealthWatch Newsletter* is published The Editor will find space for a brief account of what the WHO thinks about the efficacy of homeopathy.

Meanwhile, there are several other public statements that deserve close scrutiny about the proven efficacy of treatments, to answer the question “CIBeT?”. But I promise that in future CIBeT reviews I will never again lead you astray with fictional scenarios.

John Garrow

*Emeritus Professor of Human Nutrition, University of London*

### news in brief

GERONTOLOGIST, philosopher and prolific author Professor Raymond Tallis will be the speaker and award-winner at HealthWatch’s nineteenth AGM and Open Meeting this October. The meeting, which is free and open to all, will take place on Thursday 18th October 2007 at The Medical Society of London at 11 Chandos Street, W1G 9EB.

THE COMPULSIVELY readable Improbable Science website run by Professor David Colquhoun, the distinguished University College London pharmacologist, was moved recently to <http://www.dscience.net/quack.html> following a complaint from a herbalist, but we have just learned that it will shortly be restored back to its original home at the UCL server.

ANOTHER website that will fascinate anyone interested in the follies of some alternative psychological approaches to health is run by the Association of Skeptical Enquiry, whose chairman is Chartered Clinical Forensic Psychologist Dr Michael Heap. In-depth and well-written articles, packed with enthralling and bizarre case histories, explore issues such as psychic healing and hypnosis. See <http://www.aske.org.uk/>

NEW AND UPDATED position papers are being prepared by HealthWatch experts on a number of subjects and are a useful reference source. Along with Les Rose’s paper on homeopathy which appears in this issue (page 4), new papers are expected shortly on subjects including cancer. See [www.healthwatch-uk.org/position.html](http://www.healthwatch-uk.org/position.html)

# THE REGULATION OF HOMEOPATHIC MEDICINES IN THE UK



**O**N 1ST SEPTEMBER 2006, UK regulations came into force which permit homeopathic medicines to carry indications on their labels<sup>1</sup>. Hitherto, only such products on the market before 1971, when the 1968 Medicines Act came into force, could carry such claims under a ‘licence of right’ (in common with all other medicines at the time). All homeopathic products marketed after 1971 are not allowed to carry indications for the diseases they claim to treat. There are currently about 3,000 homeopathic licences, and it is no surprise that the vast majority are licences of right. This contrasts rather sharply with the situation of orthodox medicines, for which virtually no pre-1971 licences exist today.

The new regulations stem from a desire to resolve this obviously anomalous situation, driven by a European Directive. The Medicines and Healthcare products Regulatory Agency (MHRA), issued a consultation on its proposals in February 2005. Four options were offered. Essentially these were (1) to do nothing, (2) to revoke all licences of right, (3) to allow efficacy claims based on non-clinical trial data, and (4) to do the same as (3) but also to review all licences of right on a voluntary basis. The MHRA states that the consultation responses were in favour of the last option, and this is now embodied in Statutory Instrument 2006 number 1952. The new regulations were laid before Parliament four days before the summer recess, and came into force on 1st September 2006, over five weeks before the new session, giving no opportunity for debate. Interestingly, the MHRA says that there were no strong public health reasons for taking any action, and that the only reason for rejecting the first option was the expectation of agitation by the homeopathy companies.

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**“In its explanatory notes, the MHRA admits that homeopathic products ‘have difficulty in demonstrating efficacy in clinical trials’. This is no different from saying ‘they do not work’.”**

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Although one purpose of the regulations might have been to encourage manufacturers to transfer efficacy claims from serious conditions to minor conditions only, a by-product is to allow such claims without the need to provide any supporting evidence. Instead, the MHRA will accept what it calls “non-scientific data” - its own words. In its explanatory notes, the MHRA admits that homeopathic products “have difficulty in demonstrating efficacy in clinical trials”. This is no different from saying “they do not work”. Data now acceptable can come from homeopathic “provings”. It cannot be over emphasised that “provings” have nothing at all to do with efficacy, and are carried out by giving healthy people undiluted homeopathic stocks. These may be of plant, animal, or mineral origin. The symptoms elicited by this process are imagined to indicate the diseases which the ultra-dilute finished product is able to treat, on the principle of “like cures like”. This, the so-called “law of similars”, is not supported by any scientific evidence. Indeed, since the new regulations appeared, a meta-analysis has appeared which shows that there is no consistency or reliability for studies of provings published from 1945 to 1994<sup>2</sup>. Thus the already scientifically invalid basis for the MHRA’s proposals is also invalidated by the homeopaths themselves. The other main principle of homeopathy is the “law of infinitesimals”, the idea that medicines become more potent the more they are diluted. There is of course no evidence to support this either, and it is in conflict with all that we know about pharmacology, therapeutics, and indeed physics and chemistry themselves.

In addition, the new regulations accept as evidence, proof that the product has been used for the claimed indication “within the home-

opathic tradition”. Obviously neither this requirement, nor “provings”, is anywhere near a definitive test of efficacy. The regulations do not list any other types of evidence as acceptable. Potential sources of data were listed as including homeopathic pharmacopoeiae and materiae medicae, and bibliographies, such that they would be accepted by homeopathic practitioners. In other words, all that is necessary is to convince homeopaths, and it is not necessary to win over anyone with a more scientific view of medicine.

The MHRA prefaced its consultation by stating quite clearly that clinical trial evidence was lacking. Interestingly, not one of the various homeopathy organisations which responded enthusiastically to the consultation even suggested that such a view might not be correct, despite vociferous claims from many homeopaths that clinical trials do show efficacy. It is not too difficult to find such positive trials if one ignores the matter of methodological quality. This might explain why, despite two centuries of use, the clinical evidence for homeopathy actually gets weaker over time<sup>3</sup>. The key question which any scientist, and the MHRA in particular, should ask is: “After 200 years why are we still arguing about the efficacy of homeopathy?”.

The MHRA published a summary of responses to the consultation<sup>4</sup>, but omitted to mention that three medical Royal Colleges strongly criticised homeopathy. The Royal College of Physicians stated that, “it is important that unsubstantiated or false claims of efficacy are absolutely prohibited”. The other critical Royal Colleges were those of General Practitioners, and of Physicians (Edinburgh). Certain other groups, such as the National Eczema Society, voiced very similar objections. However the Royal College of Radiologists very warmly supported option (4), while all along mistaking homeopathy for herbal medicine. The Royal College of Nursing was even more enthusiastic, but the response was written by a homeopath. Several other organisations issued critical statements, including the Royal Society, The Academy of Medical Sciences, the Biosciences Federation, the Medical Research Council, and the Royal Society. The British Pharmacological Society (of which the MHRA’s chief executive and chairman are both members) said:

*“The British Pharmacological Society believes that any claim made for a medicine must be based on evidence, and that it is the duty of the regulatory authorities, in particular the MHRA, to ensure that no claims can be made for the efficacy of any form of medicine unless there is good evidence that the claim is true. Despite many years of investigation, we have no convincing scientific evidence that homeopathic remedies work any better than placebo. Pharmacologists have noted frequently that most homeopathic products are diluted to the extent that they contain no molecule of active ingredient, that is, no medicine, which is highly misleading to consumers who are unlikely to recognise the expression “30C” for example. Furthermore, there are serious concerns, even in cases where they are used for minor ailments, that officially endorsed use of such remedies may put patients at risk of delayed diagnosis. The Society is therefore surprised that the national rules*

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# INSULIN MURDERS: true life cases

by Vincent Marks and Caroline Richmond

Published by RSM Press 2007 in paperback ISBN 978-1-85315 760-0 price £12.95



**A**S A REGULAR reader of detective stories I was delighted to review this “true life” book of fourteen short stories taken from Professor Vincent Marks’ fascinating personal casebook. Professor Marks is a renowned world expert on clinical biochemistry with a special interest in nutrition, diabetes and the effects of insulin.

He is also a long-standing and active member of HealthWatch who invited Caroline Richmond, a well-known medical journalist and a fellow founder member of HealthWatch to collaborate with him in the presentation of some of his most challenging and high profile cases.

I found the text of most of the “stories” both readable and interesting though there are times when there is a slightly uneasy balance between the detailed scientific explanation and the human interest “plot”. Presumably, in order to ensure that each story or chapter can be read independently, there is inevitable repetition of the explanation of the various technical procedures that were or should have been used in the detection of insulin traces (and the types of insulin) before and/or after a suspicious death and the advantages and disadvantages of the different tests available at the relevant times and places.

The book moves chronologically forward, starting with the conviction of Kenneth Barlow (a state registered nurse in England) which the book describes as “the first documented case” of murder by insulin and which pre-dates Vincent Marks’ entrance onto the forensic stage as an expert in this field. Barlow was convicted by a jury for the murder of his wife Elizabeth with insulin which he had injected claiming she had done it herself. After 26 years in prison Barlow was still protesting his innocence when he was released in 1984. Marks concludes that although the insulin administered by Barlow certainly played a crucial part in her death, she did not die from its effects - it may or may not have been sufficient to kill her given time but Barlow became impatient so while she was unconscious he drowned her in the bath and then dumped her on the bed!

**“Had Von Bulow not had wealthy and influential friends who bankrolled his defence he, ‘would not have received justice’ - the costs of which are estimated at \$3.5millions.”**

Having recently seen the film “Reversal of Fortune” starring Jeremy Irons on television I was, however, particularly interested to read the “inside” take on the Claus von Bulow trial. In the film, it is strongly suggested that Claus Von Bulow was either active or was complicit in the attempted murder of his wife Sunny by injecting her with insulin and/or leaving her unconscious in her bathroom on a freezing winter day with the window wide open and that it was only due to the bril-

liance of a clever academic lawyer that the guilty trial verdict reached in 1982 was deemed unsafe in 1984. Von Bulow changed his legal team and his medical expert witnesses thereafter and he was eventually acquitted in 1985. Vincent Marks, who gave evidence at the later trial, provides the reader with a very different and compelling scientific explanation of what actually occurred. He is certain that Von Bulow never gave his wife insulin and that there was never any credible evidence to support this allegation. The authors explain that this was the first criminal case in which immunoassay played a vital role in elucidating the role of insulin in inducing hypoglycaemia and unfortunately proved to be wanting. The Von Bulow case, according to Marks and Richmond, highlights how a case that is totally without merit and that should never have been initiated in the first place can lead to an innocent person being convicted of a non-existent crime merely for lack of expert knowledge and the difficulty of conveying complex scientific facts to a judge and jury. Had Von Bulow not had wealthy and influential friends who bankrolled his defence he, “would not have received justice” - the costs of which are estimated at \$3.5millions! His former wife has survived for 25 years in a persistent vegetative state.

The Von Bulow case, “illustrated the problems encountered in using methods and techniques that serve a useful purpose in clinical medicine but are not necessarily suitable for use in the forensic situation. This is a recurring theme throughout this book, in which at least one other miscarriage of justice was...based on misinterpretation of the unreliable laboratory data (see the Winzar case, page 106).” The Winzar case is also championed by the authors as a depressing miscarriage of justice that has not been reversed and that we must hope is very rare.

Another familiar case discussed is that of Beverley Allitt, the nurse who murdered babies in hospital by injecting them with insulin. In addition there are cases from around the world - ranging from USA to Japan to Germany.

Verdict: Highly Recommended. Informative and thought provoking.

Diana Brahams

Barrister and HealthWatch Committee Member

*Insulin Murders: true life cases* is published by the Royal Society of Medicine Press. It is available from good booksellers or can be ordered online direct from [www.rsmppress.co.uk](http://www.rsmppress.co.uk)

## Position paper: homeopathy

*scheme for licensing homeopathic products, which came into force on 1st September (Statutory Instrument 2006 1952), will regard non-scientific data as evidence of efficacy.”*

By now, readers may be wondering what is driving such a bizarre move. The answer might be found in the MHRA’s own Regulatory Impact Assessment<sup>6</sup>. It is stated there that not to act thus would “inhibit the expansion of the homeopathic industry”. This is the first time that the MHRA has admitted to a commercial remit. It is not in its mission statement, but this is:

*“We enhance and safeguard the health of the public by ensuring that medicines and medical devices work and are acceptably safe. No product is risk-free. Underpinning all our work lie robust and fact-based judgements to ensure that the benefits to patients and the public justify the risks.”*

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HealthWatch committee member*

**ACKNOWLEDGEMENT** Adapted with the publication’s permis-

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# MY LYMPHOMA AND ME

**I**N 1994, 13 YEARS AGO, I was diagnosed with a low-grade non-Hodgkin's lymphoma. A cheerful oncologist delivered the diagnosis, adding with a radiant smile that the good news was that I didn't need any treatment. I was appalled by this, and left the consultation wondering whether the doctor was callous, untruthful, or just plain lazy. One of my first priorities was to get myself referred to another hospital. The other was to find out more about my kind of cancer.

There was little or no Internet material in those days. I rapidly found a book called Everyone's Guide to Cancer Therapy by Dollinger and others, then in its first edition. It is now in its fourth, and is excellent.

One of the first things I read was that my type of lymphoma is incurable, and I can recall the *thunk* as my heart hit my shoes. The better news was that survival from diagnosis was typically 6-12 years. The book explained why I wasn't offered treatment: it doesn't improve long-term survival and if a patient's tumours are not bulky or unsightly there is no benefit to be gained from immediate action.

I continued working, and the disease and its treatment made little difference to my life, though they probably made me less energetic than I might otherwise have been. Over the years, I had two courses of oral chemotherapy with a drug called chlorambucil. I didn't suffer any obvious ill effects. Later, I was one of the first patients to be treated with a monoclonal antibody, rituximab, and was one of the minority who have a complete remission: I remained tumour-free for 18 glorious months.

I had two lots of radiotherapy. One was to irradiate the left side of my neck and chest. The other was targeted at two bulky tumours - one in an eyelid, and the other on my temple. The consultant radiologist was excellent, and gave me full explanations and clear counselling.

The radiographers who administered the therapy were less good: they left me unnecessarily naked for long periods, made appointments for me without telling me in advance (so that I was left with a last-minute choice of missing my treatment or cancelling a lunch-eon party I was hosting), and tricking me into consenting to Prussian blue tattoos on my chest by telling me they would be black, under my chin, and would look like a tiny natural freckle.

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**"the nurses on the cancer ward frequently offered me reflexology ... but when my toenails needed cutting and I was too weak to do them myself, a nurse said apologetically that regulations forbade her"**

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The tattoos have caused me long-term distress. I haven't been able to wear a v-necked garment for seven years. Having them removed privately is outrageously expensive and I am now currently waiting to have it done on the NHS.

The book also warned that some people with low-grade (i.e. slow-growing) lymphomas develop high-grade lymphomas; there is a 30% chance of this happening over ten years. I developed a high-grade lymphoma eight years after initial diagnosis.

The first I knew of this was that a groin lump looked suspiciously large. I was prescribed another oral drug, fludarabine. A biopsy was booked for 18 days later. During that time it grew to the size of a cow pat. I told myself (stupidly, with hindsight) that I should wait for the appointed date and not try to hurry things along. By the time of biopsy I was having difficulty breathing, caused by fluid in my chest; this was caused by tumour blocking the lymph that normally drains through the chest. The condition was called pleural effusion. It was drained off, a painful process that had to be repeated many times and became increasingly more difficult. The fludarabine was stopped as it clearly wasn't working.

The treatment plan was to give me two complete courses,



totalling nine sessions, of chemotherapy. In between, I was to have a long-term catheter, called a Hickman line, inserted into my chest. Three of these sessions were to last four days each, during which time I walked around with a pressurised bottle of chemicals infusing, through a Hickman line, a catheter leading to my vena cava. Then I was to have my blood stem cells collected and stored, after giving me drugs that made them proliferate. Then, after a rest, I was to have high dose chemotherapy. This would kill my bone marrow cells, but a self-transplant would put this right. My chances of being alive in 12 months time were about 50% with the stem cell transplant, and 50% without.

The high dose chemotherapy and stem cell transplant was cancelled as the cancer had relapsed, as shown all too clearly by the return of pleural effusions. I had more chemotherapy, three five-day cocktails as an in-patient. The pleural effusions became frequent and severe, requiring frequent hospital admissions, often as an emergency. I needed an oxygen cylinder at home. I underwent surgery to stick the pleural membrane together on one side of my chest, to prevent further fluid accumulation. The surgery went badly and the surgeon declined to do the other side of my chest. During this time the cardiology nurses were careless about cleaning my Hickman line.

To my surprise the last lot of chemotherapy worked and the stem cell transplant was rescheduled, five months later than the original date. My survival chances, unsurprisingly, had plummeted. They were now 1-2% overall, but 3-4% in the best centres.

The high dose chemotherapy and stem cell return went well but I developed septicaemia that lasted six weeks. It was eventually traced to the Hickman line which, for logistical reasons, could not be removed for some time as I needed a huge number of intravenous drugs.

During this time the nurses on the cancer ward frequently offered me reflexology. I did not feel the slightest desire to have my feet massaged or a lot of pseudoscience spouted at me. I feel that it was offered because the oncologists felt under pressure to offer an alternative therapy and chose reflexology (a preposterous name) as it was harmless. In contrast, when my toenails needed cutting and I was too weak to do them myself, a nurse said, apologetically, that regulations forbade her.

I had absolutely marvellous care, almost without exception, and the nurses co-ordinated with my local social services so that I had domestic help when I was at home.

I never felt the need to turn to non-evidence based treatments (I have often wondered if I would if circumstances were bad enough). In contrast, I would have welcomed skin and nail care, and if I hadn't been bald from chemotherapy I'd have welcomed a hairdresser. I was bloated with steroids and looked absolutely ghastly, and so did most of my fellow patients.

My NHS acrylic wig was excellent, and as good as anything I could have bought privately. Technically they are only available to in-patients. However, I wore it only once - to have a passport photo taken - and donated it to the chemotherapy day centre. I preferred to do Interesting Things With Scarves.

The hospital that treated me now offers Reiki therapy as well as reflexology, and both are free of charge. By offering them they are effectively endorsing them. A beautician and a hairdresser, available at little cost, would do much more for patient morale and be a better use of resources.

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# WHAT IS THE ALTERNATIVE TO MEDICINE?

Dr James May, who joined the HealthWatch Committee this year, is a GP Principal in Kennington, who has also completed an MA in bioethics. Here he takes a philosophical view on the demand for alternative remedies from patients for whom there is no magic bullet cure for their own particular ailment



**I**F A TREATMENT helps people to feel better, then is it not reasonable to use it? Whilst alternative therapies may not be able to provide rigorous scientific evidence to support their use, surely the fact that so many report feeling better on them is a sufficient reason to justify their use. So what, if they are merely working by a placebo effect? HealthWatch is about effective treatments, and alternative therapies are often effective placebos - what is wrong with that?

This type of argument is very common not just with lay people, but with clinical doctors. It is indeed difficult to argue against. If one replies that the claims for efficacy are simply not true, the argument is, "Well so what, if it makes them feel better?". Why deny people this help at least? Orthodox scientific methods could be cast as cold and uncaring in comparison to the holistic benefits of alternative medicine. When orthodox medicine no longer has anything to offer, why not use alternative medicines or complementary medicines as they are now called? The placebo effect, at its worst becomes some sort of "noble lie", a way of comforting people regardless of whether there is any demonstrable medical benefit, partly through an irrational faith that there *will* be benefit.

There is a problem with this argument, and it is a profound problem. Apart from the substantial issue of dishonesty in using the placebo effect there is a broader question about what it is that we are saying either as the prescribing doctor, or as a society in general. Are we not as a society becoming increasingly medicalised, looking to solve all our problems with medicine? Is there not the implication that there is indeed, "a pill for every ill"?

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**"Science and medicine have their limits and they should be used with due humility...There is no tablet to be taken to ease the troubles in Iraq."**

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General practice can be very frustrating. Needy people come with coughs and colds, with cancers and chronic diseases, but they commonly, normally even, bring all the problems of their lives with them. Anger, frustration, joblessness, relationship breakdowns, drug abuse, financial ruin, anxiety, fear, despair ... and it is very difficult to disentangle these from the more obviously medical issues. One person's headache may be another person's brain tumour because their father died from the same. The apparently "holistic" approach of alternativists seems usually to involve a detailed analysis of the whole person, which can range from the nature of the abdominal pain, to their family situation, even to their favourite colour. The treatment is then tailored very precisely to address the whole person - or so it is often claimed. The problem is that far from being holistic, this is actually more medicalised than the work of a good GP. At the end of the consultation it is a therapy that is given - a combination of herbs or homeopathic remedies, a particular type of massage, or a particular mapping of acupuncture sites. A good GP, however, will recognise that there is no medicine or magic bullet for these problems, because they are not medical problems. There is not a pill for every ill.

Science is very good at answering scientific questions, and medicine is remarkably successful in treating medical problems. However, as Wittgenstein observed, "We feel that even when all possible scientific questions have been answered, the problems of life remain completely untouched."<sup>1</sup> Science and medicine in other words have their limits and they should be used with due humility. That this is true is manifestly obvious when we look at large scale problems. There is no tablet to be taken to ease the troubles in Iraq. But for various reasons the same logic seems to get lost when it

applies to the individual. The individual in the modern world seems increasingly to turn to medicine, perhaps allowing some greater scope for "otherness", by using alternative medicine. But it is still medicine, a pill for that ill. This is potentially very flattering to both the orthodox doctor and the alternative healer. That people open up their troubled lives in the hope of having their problems spirited away could leave the therapist awestruck by their own power over other people's lives.

All of which raises some rather thorny philosophical conundrums. How did we as a society become "medicalised"? If orthodox medicine, alternative medicine and the placebo effect are not capable of treating these problems, then what is the alternative to medicine? If we are asking this question with genuine puzzlement then perhaps that is a sign of just how medicalised we have become.

Unfortunately the very success of science seems to be partly responsible for the failure to recognise that there are things outside the scope of science. Sometimes science seems to engulf everything. In particular human beings and their significance can be lost. In his Penguin history of science, John Gribbin's opening sentence is, "The most important thing that science has taught us about our place in the Universe is that we are not special."<sup>2</sup> Richard Dawkins said, "Sometimes I feel a visceral hatred of George Bush. In my rational mind though I tell myself that he is not a person who does evil, but a machine which is malfunctioning."<sup>3</sup>

If, however, persons are both real and special, then maybe there is good reason for rejecting alternative medicine in favour of alternatives to medicine - which means recognising the limitations of medicine.

Carl Jung observed that, "Patients force the psychotherapists into the role of priest, and expect and demand that he shall free them from distress. That is why we psychotherapists must occupy ourselves with problems which strictly speaking belong to theologians."<sup>4</sup>

What's true of psychotherapists is equally true of medical doctors and perhaps of GPs in particular. It is not easy to allow a distressed patient to leave the room without offering some therapy to ease their distress. The problem is that there is rarely a medicine that can do this job, nor indeed should there be. They are simply not medical problems.

*James May  
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## HOW MUCH NUTRITION IS ENOUGH?

**T**HE SAYING attributed to Hippocrates, "Let your food be your medicine and your only medicine be your food" is frequently invoked by nutritional therapists to justify unproven and untested supplements and diets. Nevertheless, there is convincing evidence from many epidemiological studies and randomized controlled trials that in the area of chronic non-communicable diseases such as cancer, hypertension and atherosclerosis, diet is indeed an important factor, and relatively modest changes in diet may be beneficial.



One example is the DASH diet (Dietary Approaches to Stop Hypertension)<sup>1</sup>. Two randomized controlled trials have shown that blood pressures were reduced with a diet that is low in total fat, especially saturated fat, and cholesterol, and that emphasizes fruits, vegetables, and fat-free or low-fat milk and milk products. The diet also includes whole grain products, fish, poultry, and nuts and is lower in lean red meat, sweets, added sugars, and sugar-containing beverages than the typical American (or British) diet. At a recent conference that was supported by a number of large pharmaceutical companies<sup>2</sup>, one speaker said that the DASH diet would reverse the effects on blood pressure of 20 years of aging.

I visited my GP recently and, because I am now of the appropriate age, she checked my blood pressure, raised her eyebrows and suggested I come back to have it rechecked by the practice nurse (supposedly less frightening than having blood pressure measured by a doctor - the so-called white coat syndrome). It was still high, and I was given a natty portable device that inflated every 30 minutes over 24 hours and recorded my blood pressure. No argument, I am hypertensive. My GP then asked me about exercise and smoking and discussed which of two calcium channel blockers I would prefer. No mention of my diet at all.

I cannot fault my (NHS) GP practice, it is an extremely well organised group practice, with nurses, a physiotherapist and a dietician all on hand, and an in-house pharmacy. The waiting room walls are decorated with posters, many of which carry the "prudent diet"

message. Amazingly, you can have an appointment the same day, and they open at 08:30. The fault must lie in the training given in medical schools.

Medical education has improved considerably since the Rank Prize Funds supported the appointment of professors of human nutrition in two medical schools some 25 years ago (one of whom was our Vice-Chairman, John Garrow). All medical schools include at least some nutrition in the curriculum. However, this is frequently in early years of the course, and it is difficult for nutritionists or dietitians to gain time later on, when the students are seeing patients on a regular basis. By contrast, the clinical pharmacologists have a large input to teaching - justifiably so, since medical students and doctors obviously have to know what they are prescribing and why.

I would not agree with Hippocrates completely. Your food should not be your only medicine; nevertheless, a little more emphasis on the role of nutrition would not go amiss.

*David A Bender*

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## My lymphoma and me

I went home barely able to walk a few paces with two sticks, expecting to potter around for a few weeks and then die. I slowly got stronger. It took over a year. I haven't needed any further treatment. Though I haven't had a scan since then - why look for trouble? - I don't show signs of any tumours. I have some numbness in my hands and feet, and some deafness, which I attribute to the chemotherapy - a small price to pay for being alive. My prognosis

*...continued from page 6*

is unknown.

I was 66 in April, I work pretty much full time on obituaries and other journalism. At weekends I sort, price and display secondhand books at my local Cancer Research UK charity shop. My work and people's donations bring them more than £200 a week.

*Caroline Richmond*

*Medical Journalist and HealthWatch Committee Member*

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