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DOCTORS CALL FOR STRICT CONTROLS ON PRIVATE SCREENING TESTS

HEALTH PROFESSIONALS have called on the UK government to take action against irresponsible direct marketing of private health screening tests. In a joint statement¹ issued on 24th June, the British Medical Association and the Academy of Medical Royal Colleges pressed for robust controls and strict penalties against companies who take advantage of vulnerable people by claiming falsely that the health screening they offer will detect diseases early or reduce the risk of developing specific illnesses.

HealthWatch members know that if companies make misleading claims they could be in breach of the EU's Consumer Protection against Unfair Trading Regulations. However experience with other types of health-related products suggests that bringing a prosecution is almost impossible in practice (see page 2 of this issue). The BMA and AMRC have written to the Health Secretary Andrew Lansley with suggestions for reducing the potential for harm from private screening tests. HealthWatch will watch with interest to see what action results.

The joint statement argues that screening tests offered as part of NHS programmes are supported by research evidence, and patients are helped to make informed choices. In the private sector, however, it may be, "impossible for people to distinguish between private testing services that may do some good, and those that are of no value or even potentially harmful," the BMA's Chairman of Council Dr Hamish Meldrum told the *Daily Telegraph*².

There are significant risks with direct-to-consumer tests. Many are unreliable and inaccurate. Patients may be falsely reassured, or undergo avoidable and sometimes invasive follow-up tests and treatments. Unnecessary procedures may have long-term or permanent complications which can place a burden on the NHS. Particular concerns have been expressed about whole body MRI and CAT scans and the possible future impact of genetic screening.

A few weeks ago Dr Margaret McCartney (HealthWatch Award

winner 2008) wrote in the *British Medical Journal*³ about a new £115 home screening test for cervical cancer. The test seems to be sensitive and produce fewer false positives than conventional smear tests. However, young women presenting with a positive result from home screening, yet with no clinical symptoms and in an age group in which such test results have not been proved meaningful, present the NHS with a dilemma because further more invasive tests carry their own risks. Dr McCartney's conclusion: anyone selling a test about which there are uncertainties should make them extremely clear to purchasers before the test is done.

Mandy Payne

References

1. The full BMA/Academy statement can be viewed at: http://www.bma.org.uk/health_promotion_ethics/genetics/jointstatementhealthtests.jsp
2. The Daily Telegraph article of 24th June 2010 can be viewed at: <http://www.telegraph.co.uk/health/healthnews/7850262/Doctors-attack-misleading-claims-of-private-health-screening-tests.html>
3. McCartney M. Smear fears *BMJ* 2010;340:c2830 (14th June 2010). View on: http://www.bmj.com/cgi/content/full/340/jun14_1/c2830

Note: Sense About Science's booklet, "Making Sense of Screening" is about screening in general and is available to download free of charge at: <http://www.senseaboutscience.org.uk/PDF/MSOScreening.pdf>

Award for the professor behind "Improbable Science"

THIS YEAR another esteemed troublemaker has agreed to accept the HealthWatch Annual Award.

David Colquhoun is a professor of pharmacology at University College London who has devoted his career to researching the nature of the molecular interactions that cause single ion channels to open and shut. But HealthWatch members will know him better as an outspoken critic of pseudoscience through his popular blog and website DC's Improbable Science (www.dscience.net),

which is for many of us a first port of call for informed analysis when health non-science is in the news. Last year he famously obtained a Freedom of Information judgement to require the University of Central Lancashire to release details of their BSc course in homeopathy.

The eighteenth HealthWatch Award will be presented at the 2010 HealthWatch Open Meeting and AGM, to be held on Thursday 28th October. Further details will be sent to members in due course.

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Unfair play from the Office of Fair Trading?

AS YOU'LL HAVE READ in the last issue of the *HealthWatch Newsletter*, the old Trades Descriptions Act has been overtaken by the 2008 EU Consumer Protection Regulations and any attempt to contact the Office of Fair Trading (OFT) direct is now blocked by Consumer Direct (CD) who do their best to shield the Trading Standard Officers from tedious complaints by members of the public expecting protection from those who make false claims for health products. HealthWatch members will have read about my difficulties penetrating the screen that CD sets up between the public and the TSOs. I thought the battle was over when I was recently given the phone number of a senior TSO in our local area (Herts), but I was too optimistic.

Mr P Passi kindly phoned me and said he was investigating my complaint about the claims made for Skinny Water, the product about which I'd submitted a complaint, to see if they were in any way unlawful. He had sent samples of the water to the Public Analyst, and asked him, "to check on all the nutrition and health claims made for compliance with the EC Regulation 1924/2006 on Nutrition and Health Claims made on Foods, as this is the most appropriate legislation. This is a complex task as claims are being approved by the European Food Standards Agency and at present there is a backlog of work at EFSA processing the claims presented. However I hope to have some information soon and I will let you know how we intend to proceed."

I recognised that this was Euro-speak for "Don't call us: we will call you". EFSA (like many EU agencies) could take for ever clearing their backlog of work before they even started to think about the "complex task" he had set them.

Furthermore, no amount of chemical analysis of Skinny Water, or search of previous regulations set up by the EFSA, would reveal whether Skinny Water had been "shown to suppress appetite, block carbohydrate from turning into fat, and increase fat burning ...".

These are claims about the metabolic response of consumers taking Skinny Water, and are therefore medical claims. This now sets up justification for the OFT to pass the buck to yet another regulatory body, the MHRA (Medicines and Healthcare and products Regulatory Agency). But the MHRA is not funded to enforce the Medicines Act. So who should?

It seems that the Office of Fair Trading is guilty of applying to itself a description that would have been deemed misleading under the old Trades Descriptions Act. According to the OFT's website it is "a non-ministerial government department...which enforces consumer protection ... by prohibiting unfair practices such as rogue trading, scams and cartels." That is that I always thought the OFT did, but my recent experience makes me doubt that its function is always as helpful as they claim.

John Garrow

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Editor's note:

The Office of Fair Trading website is at: <http://www.offt.gov.uk/>

NEWS IN BRIEF

THE PRINCE'S Foundation for Integrated Health (FIH) has closed its doors. An announcement appeared on the FIH website on the 30th April 2010 which said, "Whilst the closure has been planned for many months and is part of an agreed strategy, the Trustees have brought forward the closure timetable as a result of a fraud investigation at the charity. The Trustees feel that The Foundation has achieved its key objective of promoting the use of integrated health." Four days before the surprise closure, two former officials at the Prince's Foundation had been arrested on suspicion of fraud and money-laundering, with an estimated £300,000 unaccounted for in the charity's books.

See:

http://www.fih.org.uk/media_centre/closure_of_fih.html and
<http://www.guardian.co.uk/uk/2010/apr/26/prince-charles-aide-homeopathy-charity-arrested>

THE HEALTH Secretary Andrew Lansley announced in June that the government will set out new measures to protect NHS whistleblowers. Detailed proposals are awaited but measures will include unequivocal guidance to NHS organisations that all their contracts of employment should cover the rights of staff to raise concerns in the public interest.

See: http://www.dh.gov.uk/en/MediaCentre/Speeches/DH_116653

FINLAND, GERMANY and Portugal don't do it, Spain might consider it, while France and Ireland like a doctor to be involved. A survey of 14 European countries and the US has looked at the extent to which patients are encouraged to report adverse drug reactions (ADR). Direct reporting by patients results in faster and more accurate accumulation of knowledge of ADRs than can be

achieved if only health professionals are allowed to submit information. One of the report's authors is Dr Andrew Herxheimer, past HealthWatch committee member.

Download report at:

http://www.haiweb.org/10052010/10_May_2010_Report_Direct_Patient_Reporting_of_ADRs.pdf

IT IS SURPRISINGLY difficult to find out how research funders decide what research to fund. Now the James Lind Alliance has launched an online resource that should help patients, clinicians and the groups that represent them to ensure that research is grounded in what matters to them jointly. The JLA Guidebook is drawn from experience of patient/clinician partnerships in a wide range of conditions and gives step-by-step advice for establishing effective Priority Setting Partnerships and for identifying and prioritising treatment uncertainties. It includes templates for questionnaires, draft agendas, terms of reference as well as links, publications and other resources.

Download from www.JLAGuidebook.org

UNDERSTANDING UNCERTAINTY is an engaging website that seizes on figures given in news stories of all kinds and applies statistical analyses. Among the health issues considered are screening tests: for HIV, breast cancer and terrorist tendencies; while in "2845 ways to spin the risk" an interactive demonstration lets you explore the way "risks can be 'spun' to look bigger or smaller, how medical treatments can be made to seem useless or to be wonder cures, and how lifestyle changes might look worthwhile or not worth bothering with." Worth a visit.

Go to: <http://understandinguncertainty.org>

PITY THE POOR (CLINICAL) WINNER



ON JUNE 15TH the Medical Journalists' Association held a meeting to discuss "Libel law reform: What every medical journalist should know". Attendance was extended also to members of HealthWatch, Sense about Science and the Guild of Health Writers. The chairman was John Illman, and the three invited speakers were Simon Singh (the science writer and author who was sued for libel action by the British Chiropractic Association, but he won), Peter Wilmschurst (the cardiologist who is currently being sued by a US medical device manufacturer) and Tim Smith, an expert in libel law.

There was an audience of about 60, mostly medical journalists. A show of hands indicated that the large majority had experience of being sued for libel, or threatened with legal action if they did not apologise and withdraw some defamatory publication. Apart from Peter Wilmschurst I saw only two other clinicians in the audience.

Accounts of the legal battles of Singh and Wilmschurst are available elsewhere^{1,2}. The complexities of English libel law, though ably explained by Tim Smith, are beyond my understanding. What I learned was that it is amazingly easy and inexpensive to enter a claim of libel in the High Court in London, that if the litigants win the defendants are charged eye-watering costs, and *even if the defendant wins he is still substantially out-of-pocket in the end*.

Just to confirm that I had correctly understood the italic note above I asked the platform party if they could quote any libel action, in the English court in the last decade, in which a winning defendant had come out of the trial without having lost a substantial amount of money. None of the experts could remember such an event.

Smith said the advice he gave to defendants who were not rich was to apologise and withdraw the defamatory statement. It was not true that if you fought on and won you would have your costs fully paid by the litigants—their lawyers would challenge every item of the costs you claimed back, and these lawyers are known to charge £800 an hour for their work! There was consensus that recovering 70% of your costs is about par for the course.

It follows that the most economical strategy for the defendant is to apologise and withdraw or, cheaper still, not to publish anything defamatory, however true it may be. From the journalists in the audience there were many who said that medical journals were now edited by the in-house libel lawyer who vetoed anything that might attract libel threats, and there were many apologies that were known to be made to save money rather than correct errors of reportage.

"when a large organisation seeks to stifle criticism it picks on the weakest target first. In a clinical trial, the individual clinician who speaks out is an obvious target"

All of this was very interesting to journalists, but Dr Wilmschurst pointed out that he did not have the luxury of choosing to apologise and withdraw his criticism. He is being sued by US medical device manufacturer NMT Medical Inc over his speculation about the effectiveness of their device for mending a hole in the heart. He was certain that his concerns were valid, and that future patients opting for this device needed to know about concerns over its effectiveness. If he withdrew then NMT could claim this as a vindication that their patch was safe and effective. You can find the company's position on the device and patent foramen ovale on their website³.

The MJA meeting was to provide, "What every medical journalist should know", but clinicians need to know a bit more than that. If a clinical researcher (like Dr Wilmschurst) carries out a controlled trial of a treatment and discovers that there is a serious (but infrequent) side-effect, he has a responsibility to publish this fact. If the sponsor of the trial sues him for libel since this information is defamatory he has two options, neither of which are acceptable:

Option A: he can withdraw his criticism, say the treatment is perfectly safe and effective, and probably receive a handsome consultancy fee from the sponsor of the trial.

Option B: he can protest that he has a moral duty to ensure that the publication of the trial results is true, and to see that both the good and bad effects are honestly reported. If he takes this route he is at risk of being defamed by the sponsor as being malicious and dishonest, and involved in litigation that puts him and his family under pressure of bankruptcy.

Everyone at the meeting agreed that the libel laws should be reformed, and realistic estimates are that this might happen in 2011 or 2012 (see page 7, this issue).

But what can happen meanwhile? Tim Smith made the interesting observation that when a large commercial organisation seeks to stifle criticism it always picks on the weakest target first. In a clinical trial, the individual clinician who speaks out is an obvious target. We will never know how many clinicians have taken option A above. It is in the public interest that more should take option B.

So what can be done to support option B clinicians? Smith advises journalists to take out insurance against libel threats, so they have more protection from financial attack, but of course the insurance costs the journalist money.

Clinicians are obliged to take out professional insurance to cover them against complaint about malpractice. Many years ago I published results of our trial that showed that the weight lost by obese patients on a commercial very low energy diet contained more lean tissue and less fat than was desirable. The vendors of the diet wrote to me to say this was defamatory and was damaging their sales of the diet. I sent this to my insurers who told me not to reply, but to send any further letters to them and they would reply. I heard no more from the vendors of the diet, presumably because I was no longer a weak target.

Peter Wilmschurst has professional insurance as part of his job requirements. The libel threat from NMT arises from work he did at the request of his employers—the NHS Trust. The payment from NMT for the work done by Wilmschurst as part of the trial went to the Trust, not to him. It seems bizarre, then, that his professional insurance is not supporting him in his admirable adherence to the ethics of his job. Perhaps his insurers think that he will win his case and get all his costs back.

That is what I used to think, but now I have learned to pity the clinical "winner".

John Garrow
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1. The history of Simon Singh's case, with links to press coverage, can be seen on the Sense About Science website: <http://www.senseaboutscience.org.uk/index.php/site/project/478>
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3. View on: <http://www.nmtmedical.com/heartrepair.aspx?id=78>

CAM AND NARCISSISM or “BUT IT WORKS FOR ME”



MAGIC AND SUPERSTITION have been declining since the time of the Reformation in the UK¹. By the 1940s and 50s there was little sign of it expressing itself in alternative medicine. However, from the 1970s complementary and alternative medicine (CAM) grew rapidly in popularity², becoming the large scale industry it is today. The question arises why, given the expansion of effective modern medicine in the last 80 years, is there a renewed enthusiasm for irrational beliefs about medicines? Is it simply a matter of failing scientific education, or are wider cultural forces at work?

It is well (if crassly) said that, “culture eats strategy for breakfast”. A narrow focus on “the public understanding of science” may prove to be insufficient to counter the cultural torrent. It is worth noting that it is not clear to what extent such informed rationalism contributed to the earlier decline of magic. Keith Thomas, the Welsh historian and author of *Religion and the Decline of Magic*, writes, “One cannot simply attribute the change to the scientific revolution. There were too many ‘rationalists’ before, too many believers afterwards, for so simple an explanation to be plausible.”³

A clue to our current cultural condition lies in the predictable response given by a user of CAM when confronted with the evidence for its ineffectiveness: “Yes, but it works for me.” Today, sadly, “me” seems to trump reality.

This observation corresponds with the analysis of another British historian, the late Roy Porter, regarding the resurgence of alternative medicine. “Flexibility, permissiveness, variety, self-discovery have assumed greater status in our culture of self-enhancement or narcissism.”⁴

The roots of our modern Narcissism⁵ arguably lie as far back as the first modern philosopher Rene Descartes. His famous assertion, “*Cogito ergo sum*” (I think therefore I am), was an attempt to provide a foundation for certain objective knowledge. Since it is only possible to be completely objective if you stand outside the system, the cost was to philosophically remove the subjective observer from reality. The problem with this is that such god-like objectivity isn’t ours to be had. We do not stand outside reality; we are an integral part of it.

Descartes had thus, entirely unwittingly, created a monstrous subject. But the consequences of this philosophical move would take centuries to work out in the day to day lives of ordinary people. Is this too abstract? Please bear with me.

Subsequently we have experienced the Industrial Revolution, which has arguably had a bigger impact on our social existences than any other revolution before or since. The previous integration of home and work life was broken up into private and public spheres. The public work world is the impersonal world of faceless bureaucracy where people become numbers in the system, whereas the private home world is where we feel that life has meaning and significance.

Unfortunately medicine itself has been bureaucratised. Doctors (and I include myself) have had to largely stop visiting patients at home, and expect them to come to see us in a health centre or hospital. Yet it is in the private world of home where individuals feel known personally and make decisions for themselves—what colour wall paper, whether to write a novel or buy a Nintendo. Indeed consumerism is another impact of the industrial revolution—we buy

things not because we really need them, but because advertisers and social pressures make us feel that we ought to have them.

Technology’s relationship with the “self” is ambiguous. Certainly the successes of technology contributed to the decline of magic as society gained some control over the contingencies of nature, which rendered people powerless against disease and disaster⁶. However, more recently all-pervasive technology has given the illusion that it is the only place to look for answers. Porter described the “growth of the therapeutic state and the medicalized society”. If one is subject to anxieties despite technology then it is not clear where else to look for answers. The paradox here is that anxieties have been rising in recent decades at the very time that technology and success in medicine has

taken hold. Porter documented this as the “doing well, feeling bad” syndrome.⁷

Psychologically we have the advent (with thanks to Carl Jung) of existential self-psychology⁸. Visiting the self-help section of a book shop is the best way of understanding this phenomenon. It invariably neighbours the philosophy section but in a separate section with alternative medicine books. It seems the problems of life can be solved by focusing on the needs of the self. However, the self is properly defined in its relations to the external world, so that to look to the self to solve the problems of the self is to ignore reality, and—it must logically follow—to end up losing the self.

“the emphasis by CAM therapists on sensory experiences ... focus on the “history” of the “self” ... all of this is designed to make the “self” central and reassure it that it is really real”

Narcissus was a man famed for his beauty and proud of it. He glimpsed his reflection in a pool and fell in love with himself, not realising that it wasn’t reality but an image he was looking at. As a result he didn’t eat or drink and, pining for himself, he wasted away. It is a powerful myth which seems to have very modern resonances. The self is something which should not be the focus of our attentions. If it is, we will waste away for want of reality.

Reflections are insubstantial and ephemeral, like a change of clothes, so that by trying to understand ourselves, we understand ourselves less and less. So we turn to astrology to tell us about ourselves, and we can’t stop looking in mirrors or searching photos for ourselves, as if to check we are still there. Reality is redefined as what impacts me existentially, and so we seek intensity of feelings over profundity of truth and reality. We immerse ourselves in phys-

ical sensations; bungee jumping and drug taking, or eating disorders and deliberate self-harm.

Our culture is therefore ripe for CAM. The therapists often come to your home, or operate from theirs; there is an emphasis on sensory experiences: aromatherapy, whale music, massage, light touch or needle insertions. Even more significant is the focus that CAM therapists give to the “history” of the “self”, either by asking questions about trivialities like one’s favourite colour, making connections between quite unrelated subjective symptoms or by appearing to magically divine information about the self by cold reading. All of this is designed to make the self central and reassure the self that it is really real.

It would be wise for promoters of evidence-based medicine to be aware of these realities. An excessively mechanistic or reductionist philosophy, which treats people as machines or as numbers in the system, risks feeding into these narcissistic drivers. If doctors are tempted to exchange a good bedside manner for an effective medicine (as Porter suggested they are), then they should think again. Although randomized controlled trials are required to randomize patients in large numbers for the purposes of research, it would be a mistake for clinicians to treat individuals as numbers. I remember one consultant telling me that he sees himself as a mechanic trying to fix the machine. But people need to be treated holistically as subjects embodied in reality, not as abstract objects, or free-floating narcissistic selves.

How do we break the spell of the self? CAM therapists make a category error. “Holistic” medicine should not mean treating the self *apart* from reality. Rather, it is the humble recognition that doc-

tors, patients and effective therapies each form a *part* of reality. Doctors and health care professionals need to concentrate on caring for others, and seeing curing as a means to caring for the whole person. Any attempt to treat people as objects for the purposes of “objectivity” is more likely to be part of the problem than the solution. Our addiction to the reflection of ourselves is going to be a hard habit to break, and the solution is not simply better scientific education.

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4. *Ibid* page 699.
5. The rise of narcissism is charted by US psychologists and professors Jean M Twenge and W Keith Campbell in their research and in their book The Narcissism Epidemic: Living in the Age of Entitlement. Free Press, 2009.
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“No reliable evidence”: on the nature of evidence and open or closed minds

MANY ENTHUSIASTS of CAM, it seems to me, have a view on the nature of evidence which fundamentally differs from the dominant view in mainstream medicine. Let me explain. Imagine a treatment for which virtually no reliable evidence exists. Take crystal therapy as an example. You may think crystal therapy is nonsense. But enthusiasts of this treatment will quickly explain that there is no evidence either way.

And they are, of course, right—not a single clinical trial of crystal therapy has ever been published. So is it fair to say that there is “no reliable evidence”?

More generally speaking, “no reliable evidence” can correspond to several different situations. There could be some evidence but it is too flimsy to be reliable, or there might be a few good studies but their results are contradictory, so the totality of the evidence is not reliable. And, more often than not, we have no trial data at all (as for crystal therapy).

In conventional medicine, any of these three situations would mean that the treatment in question is characterised as unproven. Responsible doctors would not normally advocate an unproven treatment for routine healthcare. In fact, if they did, the GMC would have something to say about it, I’m sure. A therapy is considered unproven in medicine until it is proven. This is a crucial principle; it is important for the protection of vulnerable people—without it, patients could never be sure whether they are being treated with the best possible therapeutic option.

In CAM, all this can be very different. Here enthusiasts regularly draw quite different conclusions. If there is “no reliable evidence”,

they might feel that the treatment in question might still work. And if it is felt that it “might work”, it is often deemed all right to use it routinely. In this upside-down world, intuition and belief reign over evidence and science. Every therapy is given the benefit of the doubt. A treatment is considered “possibly effective” until it is proven to be ineffective. If we take this to its logical conclusion, almost everything can be assumed to be potentially useful, because proving a negative is rarely possible.

If I argue with CAM enthusiasts against this attitude, I am accused of lacking an open mind. But whose mind is open and whose is closed, I wonder? To rely on evidence is, I think, open-minded. Evidence evolves, and to keep up with this evolution requires an open mind. The “everything goes” attitude of some CAM enthusiasts does never change, not even in the face of evidence. Isn’t this the definition of a closed mind?

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GIVE HEART DISEASE THE BRUSH-OFF

Keith Isaacson, consultant orthodontist and HealthWatch Committee member, is pleased that he now has another good reason to encourage patients to follow his advice



FOR ALL my professional life I have been encouraging patients to be more enthusiastic about brushing their teeth, mainly for reasons of dental health. However, research recently published in the *BMJ* gives me another reason to encourage my patients—tooth brushing has been linked to a lower incidence of heart disease.

It is already known that there is a link between cardiovascular disease (CVD) and periodontal disease²—a common chronic inflammatory condition, which in turn is linked with poor oral hygiene. Findings from this latest study using cross-sectional survey data from a large sample has further strengthened that link.

For years it has been known that coronary arteries can get furred up by atherosclerosis, a cause of heart attack. Some causes of atherosclerosis—smoking, obesity—are well established. But what is less widely known is that chronic low grade inflammation increases blood levels of some of a group of chemical markers which are also associated with atherosclerosis³. A common cause of chronic inflammation is periodontal (gum) disease, which in turn usually results from poor oral hygiene. Once gum disease has set in, it is likely to continue for years unless the patient can be motivated to improve their tooth-brushing technique and to undergo regular scale-and-polish sessions with a dental hygienist. So if cleaning your teeth keeps your gums healthy, does it also prevent heart attacks?

Previous studies examining the association between oral health and CVD have been limited in size by the need for clinical assessment of patients to identify periodontal disease. However research has shown that periodontal disease can be consistently linked to the individual's own admission as to how often they brush their teeth⁴. This knowledge opened up the possibility of using data from a large-scale population survey.

For many years in Scotland cross-sectional surveys have been carried out. Every three to five years, interviewers visit individuals at home to collect information about their health and lifestyle. In addition to the usual health factors associated with heart disease, such as smoking and exercise, questions are asked about the frequency both of visits to a dentist and the number of times they brush their teeth each day. They are then examined by a nurse who measures their weight, height, blood pressure, and seeks consent to take a blood test.

Without the need for a clinical examination of the mouth, researchers were able to use the results of interviewers' questions and blood test results to relate tooth brushing to the risk of cardiovascular events in a sample of nearly 12,000 people.

RESULTS were taken from the 1995, 1998, and 2003 surveys of adults aged over 35 years, who had their own teeth and with no pre-existing coronary disease. The surveys were linked to a database of hospital admissions and deaths whose hospital data was examined on average seven years later, to identify if any of them had been admitted with (or died as the result of) a cardiovascular event. The disease category included patients with acute myocardial infarction, coronary artery bypass surgery, percutaneous coronary angioplasty, stroke or heart failure.

Of the 12,000 patients interviewed, nearly 5,000 participants agreed to have appropriate blood tests taken. Levels were measured of C-reactive protein (CRP), and the clotting agent fibrinogen, both of which are associated with heart disease. This subgroup who had had blood tests analysed enabled a correlation to be made between the self-reported frequency of tooth brushing

with the levels of the markers.

It is notable that of those who refused blood tests, many were less healthy, with higher body mass index (BMI), a higher prevalence of hypertension and CVD; they also took less exercise and smoked. However, complex statistical analysis was used to eliminate the influence of other conditions.

As a dentist I was pleased to read that oral health behaviour was generally good, with about 62% of participants reporting regular (at least every six months) visits to a dentist and 71% brushing their teeth twice a day. Those who brushed their teeth less often tended to be slightly older, male, of lower social status and with a high prevalence of risk factors including smoking, physical inactivity, obesity, hypertension, and diabetes.

"Participants with poor dental hygiene were at 70% higher risk of CVD events compared with those who said they brushed their teeth twice a day."

During the eight years of follow-up there were 555 cardiovascular disease events, of which 170 were fatal. In about 74% of admissions the principal diagnosis was coronary heart disease. Participants who cleaned their teeth less frequently and who had poor dental hygiene were at 70% higher risk of cardiovascular disease events and of death from CVD compared with participants who said they brushed their teeth twice a day.

Of course there are other predictors of heart disease which include smoking, raised blood pressure and diabetes. But these results now confirm and strengthen the suggested link between oral hygiene and the risk of cardiovascular disease.

Inflammatory markers are significantly associated with infrequent visits to a dentist and inadequate tooth brushing. Every dental professional should advise their patients that they can reduce their chance of getting heart disease and stroke by keeping their weight under control, stopping smoking and brushing their teeth twice a day.

Keith Isaacson
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SO THIS IS PEER REVIEW?

Les Rose was dismayed by his experience when asked to review a homeopathy paper for a clinical research journal. We reproduce this article from his Majikthyse blog with his kind permission.



I GET INVITED to peer review papers for a few journals, and the process is usually well managed by the editors. I have had to recommend outright rejection on rare occasions, and one of those was quite recently. I was sent a manuscript by *Evidence-Based Complementary and Alternative Medicine*. I normally regard such review work as confidential, so I won't identify the author.

However I have no compunction in identifying the journal as I have real concerns over this incident. The paper was not about evidence for CAM at all, so my first reaction was, why is it even being considered for this journal? It was actually a historical discourse, attempting to garner credibility for homeopathy by associating it with a prominent historical figure in science. I checked all the claims made in the paper, and found that even the title was factually incorrect. There were many historical errors, distortions, and inaccuracies, all of which I itemised in my review. Some tenuous links with modern science were made, which if believed by the author indicated an understanding of molecular biology that did not even reach secondary school level.

Not only was the title of the paper inappropriate for a journal about evidence, but the content was hardly scholarly and if the errors and inaccuracies were corrected, there would have been virtually nothing left. I recommended rejection with no request to revise.

Yet the editor has sent the reviews to the author and asked for a revised manuscript. I have been told that I will not be asked to review the revision, without giving a reason.

This raises two main issues. Firstly, my review pointed out errors of fact, which are quite independent from my opinion. Secondly, my experience suggested that the editorial team simply thought, "Oh well, this reviewer didn't like it so let's find another one who does". Publication bias is a problem across all areas of medical science, but it seems to be endemic in CAM journals, which rarely publish neg-

ative studies. In this case, they appeared to be planning to publish an irrelevant piece of work which I believe was engineered to put a positive spin on homeopathy yet without providing the slightest jot of scientific evidence.

It later emerged that a colleague of mine had also been invited to review the paper, and like me had recommended rejection. But that review was not on the list that I was sent. My colleague wrote to the editor asking for an explanation. The editor denied all knowledge and said that all such matters were dealt with by the editorial office. Meanwhile I had challenged the editorial office staff, who said they were only administrators and all scientific matters were dealt with by the editor. A potato too hot to handle it seems. The outcome is that the paper has been published, less some of the more ridiculous pseudoscience, but retaining the historical rubbish.

I copied my emails to the Oxford University Press, who publish ECAM, and never got a reply. I also reported the matter to the Committee on Publication Ethics, which also seems to have done nothing whatsoever. So next time you are offered a paper from a peer reviewed journal, remember this story.

Les Rose

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LIBEL REFORM BILL TABLED IN LORDS

A LIBERAL DEMOCRAT peer has published a Private Members' Defamation Bill¹ aimed at reforming England's outdated and unjust libel laws. Campaigners believe it will fight the "chilling" effect whereby fear of litigation stifles scientific debate.

Lord Lester of Herne Hill, QC, a human rights lawyer and expert in international law, hopes his bill will encourage the government to act quickly on libel reform. "We need a simpler statutory public interest defence, which clearly applies to everyone and covers opinion as well as fact," he wrote in the *Times*².

This is the first attempt in over a century to put forward a wholesale redraft of our libel laws. The bill, which had its first reading in the House of Lords on 26th May, proposes clarifying the defences of justification and fair comment, to be renamed as "truth" and "honest opinion". The bill will also require claimants to provide evidence their reputation was damaged by an alleged libel before they can bring a case forward (they don't have to do this at present) and make corporations prove financial damage before they can sue. The bill is due a second reading in the Lords on 9th July.

Supporters of free speech in matters of science had already had cause for celebration in April. Shortly after the last *HealthWatch Newsletter* went to press, the British Chiropractic Association

dropped their libel action against the science writer Simon Singh³. Commenting on the case that his solicitor says will cost him an estimated £20,000 plus more than a year's lost earnings, which he will never recover³, he told the *Times*, "My victory does not mean that our libel laws are OK, because I won despite the libel laws."⁴

Mandy Payne

References

1. Lord Lester's bill can be viewed and its progress followed on the UK Parliament website at: <http://services.parliament.uk/bills/>
2. The Times, 24th May 2010. View on: http://www.timesonline.co.uk/tol/comment/columnists/guest_contributors/article7134463.ece
3. BCA drop libel case against Simon Singh, reported on Sense About Science's website, view at: <http://www.senseaboutscience.org.uk/index.php/site/project/478/>
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For more information about the Libel Reform Campaign go to www.libelreform.org

A CASE OF MIRACULOUS HEALING ... BUT DID THE SURGERY HELP?

THERE ARE two stages in someone becoming a Catholic saint. The first is beatification, the second is canonization. Each stage, amongst other qualifications, requires that a documented miracle be attributed to the individual under consideration. In September this year, the Pope is due to come to England for the beatification of Cardinal Henry Newman.

The final judgement about the required miracle is decided by a Vatican panel, known as the Consulta Medica. Unlike the Bureau at Lourdes, who publish their findings widely, the Vatican keep a very tight control over the details of their cases. A recent study of Vatican miracles by Dr Jacalyn Duffin, a Canadian haematologist, reported that the Vatican Archives are kept sealed for the duration of the next six papacies¹. She was unable to have access to any documents after 1939.

In the Newman case, however, details in a document known as a *Positio* have been released to a handful of researchers with a specialist interest in Cardinal Newman.

One of the scholars to have read the document, John Cornwell of Jesus College Cambridge, wrote a summary of the medical evidence for the *Sunday Times*². In it he claims that the Pope has not adhered to the Vatican's own strict standards for validating miracles, and Cornwell has discussed the medical details with leading specialists in the UK.

The essential details are these. Jack Sullivan, a 61 year old trainee priest in America, suffered severe low back pain, with narrowing of his spinal cord and compression of the femoral nerves, both being demonstrated on an MRI scan. On 26 June 2000, he prayed to Newman, and the next day his pain was gone and he was able to walk without difficulty. However, after 10 months, his pain returned, resulting this time in a laminectomy, that is, a removal of bone that is pressing on the nerve, which was successfully performed on 9th August 2001.

Post-operatively, Mr Sullivan was in considerable pain and was

initially unable to walk. After six days he prayed to Newman again. He said, "I felt a surge of strength and confidence that I could finally walk." Since the ninth day post-operatively, he has been pain free and walking normally ever since.

So initial pain relief was only temporary, and the following year definitive spinal surgery was required. It had the desired effect. The rate of recovery from such procedures can vary enormously, but his recovery was judged to be within the normal range. A neurosurgeon from UCH London, who was asked to comment on these details, reported that his latest patient was 88 years old and walked out happily after two days. A member of the Vatican's Consulta Medica panel, a Professor of Medicine at the University of Rome, advised that in order to regard the healing as miraculous, they have to be satisfied that effective treatment has not been given. In this case, it most certainly was.

Peter May
GP (retired), Southampton

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1. Duffin J. *Medical Miracles—Doctors, Saints and Healing in the Modern World*. Published by Oxford University Press, 12 February 2009. Price £16.99. ISBN 9780195336504.
2. Cornwell J. Why Cardinal Newman is no saint. *Sunday Times and Times Online*, 9th May 2010. View on <http://www.timesonline.co.uk/tol/comment/faith/article7113421.ece> (accessed 15 June 2010).

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