



# HealthWatch

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## BEWARE OF MEETINGS HELD IN RESPECTABLE PLACES



**A** RECENT BBC exposé of a faith healing group making untenable claims has inadvertently highlighted the issue of off-beat organisations who achieve implied credibility by using university premises as venues for promotional and training meetings.

BBC's Newsnight programme featured the claims made by a group of healers, collectively known as ThetaHealing. According to the report on the BBC's website, they claim that their technique can teach people to use their natural intuition and "brain wave cycle" to "create instantaneous physical and emotional healing." They claim to be able to cure (and even instantly cure) cancer, a claim that is in breach of the Cancer Act 1939. ThetaHealing have about 600 practitioners in the UK who charge up to £100 per session.

Vianna Stibal, the American founder of the group, claims to have "facilitated her own instant healing from cancer in 1995". Ms Stibal now conducts seminars around the world to teach people about ThetaHealing, and has trained teachers and practitioners who are now working in 14 countries. Earlier this month, Ms Stibal visited the UK to address a meeting at the London School of Economics (LSE) where she is said to have told an audience member who asked whether it was possible to grow back an amputated leg, "I believe it's possible to grow it back... a lady grew back her ovary... you can grow back a leg. I've seen people grow back." Another ThetaHealer claimed that she made a baby's stomach cancer disappear "overnight" with healing sessions given via the telephone.

**"they were reassured the group was legitimate because the meeting was being held at the LSE"**

The healers' claims have been called "criminal" and "not supported by any kind of evidence" by Edzard Ernst, Professor of Complementary Medicine at the University of Exeter.

But the other worrying note raised in the BBC website's report was that, "Some of the 100 people who attended the event told a BBC researcher that they were reassured about the legitimacy of the group by the fact that the meeting was being held at the LSE". The LSE told Newsnight that ThetaHealing's meeting was a "normal commercial booking".

This raises a problem. Universities have excellent facilities for lectures, seminars and meetings, and are keen to rent out their prem-

ises outside normal teaching times to subsidise their own teaching activities and improve facilities for their students. The people in charge of conference bookings in universities perform their task well and provide both a good service to conference organisers and useful income to the university. However, they do not, and indeed cannot, know whether the organisations they are letting rooms to are respectable. Nevertheless, holding a meeting on university premises will give an impression of respectability.

I have twice come across this problem in my own university. Some years ago a transcendental meditation organisation wanted to rent rooms in the medical school for a conference. The administrator did not understand why members of the Academic Board were opposed to this—they'd been told that they would be well-behaved and would not cause damage—we countered that they might damage our reputation by association, and the use of our premises would confer legitimacy on their proceedings. The second case was, in some ways, more pernicious. A commercial organisation rented rooms in the medical school for a revision course for MBBS finals. They charged a high fee, and many of our students assumed that, because the course was being held on medical school premises, it was supported by the medical school, and was of an appropriate standard. It was not.

In a similar vein, there have been occasions in which someone has written a letter to *The Times* (or another similarly reputable newspaper), and has then quoted his/her letter saying "as *The Times* of such and such a date said", implying that it was editorial matter in the respected newspaper, and not a letter written in support of the claims.

David A Bender

*Emeritus Professor of Nutritional Biochemistry  
University College London*

### Reference

BBC Newsnight, 22 June 2011. Read the BBC's report and view video on: <http://news.bbc.co.uk/2/hi/programmes/newsnight/9519657.stm> (accessed 27 June 2011).

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## news

## A FEAST OF EVIDENCE IN AFRICA

**T**HERE HAS been well-deserved coverage in the press about the results of the FEAST Clinical Trial, a recent reminder that the practice of evidence-based medicine is not a lifestyle choice but a matter of life or death.

This groundbreaking trial found that an emergency treatment called Fluid Resuscitation, which is used worldwide, does not in fact save lives when used for African children suffering from shock and severe infections. Researchers at hospitals in Uganda, Kenya, and Tanzania found that giving these children fluids slowly, as opposed to using rapid fluid resuscitation, is safer and more effective in aiding recovery in the shocked critically ill child with malaria and septicaemia.<sup>1</sup> The findings challenge current WHO guidelines on how best to provide fluids to children in Africa.

The 10-minute video report on the trial, posted on YouTube, is worth watching.<sup>2</sup> It makes the point that treatments researched in developed countries, in well-nourished children and with intensive care units to hand, may be tragically inappropriate in children with a poorer standard of living and in hospitals where only basic care is available. FEAST is funded by the Medical Research Council, London, and the full research report is published in the *New England Journal of Medicine*.

After a recent *Lancet* report<sup>3</sup> brought his attention to the findings, John Garrow wrote: "I qualified in 1952 and immediately went as an intern the newly opened teaching hospital in Jamaica. All the expat staff (because the local students had not yet qualified) had been brought up to apply critical tests to the therapies that were traditionally used, and very often we found that they were not effective, or even harmful. That is what clinical research is all about.

"When I returned to the UK clinical research was still finding errors or weaknesses in current therapies, and yes, I was able to show that aspects of nutritional treatments that I had used proved to be wrong, so I changed my practice.

"There is nothing shameful about finding that treatments you thought were good are not so good, and therefore changing what you do. What is shameful is NOT finding that treatments you thought were good are not so good. That is a valid criticism of CAM practitioners. I have never heard of a CAM doctor saying proudly that he has found a flaw in the way he is using homeopathy (or whatever). Have you? But that is exactly the information that journals supply about orthodox medicine."

Mandy Payne

### References

1. Maitland K et al. Mortality after Fluid Bolus in African Children with Severe Infection published *NEJM*; May 26, 2011 and downloadable free at: <http://www.nejm.org/doi/pdf/10.1056/NEJMoa1101549> (accessed 27 June 2011).
2. The FEAST Clinical Trial. <http://www.youtube.com/watch?v=hK9VUkL-DqU> (accessed 27 June 2011).
3. Laurance J. Costing Lives. *Lancet* 2011 377 (9782): 1996. See: <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2811%2960852-0/fulltext> (accessed 27 June 2011).

**DIARY DATE: The 2011 HealthWatch Annual General Meeting will take place on the evening of Tuesday 18th October at the Medical Society of London**

## NEWS IN BRIEF

BMA MEMBERS have voted unanimously to adopt into policy a call for a stronger public interest defence and a restriction on the ability of commercial organisations to sue for libel. The motion was put forward at their annual representatives meeting (ARM) in Cardiff on 27th June in support of cardiologist Dr Peter Wilmschurst (whose story features in page 3 of this issue). The motion also called for a more rapid process to enable cases to be heard quickly; and that costs of litigation should be proportional to damages awarded.

<http://www.senseaboutscience.org/news.php/125/british-medical-association-votes-unanimously-for-robust-libel-law-reform> (accessed 27 June 2011).

US PHYSICIANS who voice concern about patient care routinely face institutional retaliation, claims an article in the *Lancet Oncology* of 29th June. America's Whistleblower Protection Act should protect government employees who expose waste or threats to public health, but in medicine these protections are increasingly under threat from court decisions. Military clinicians face especially tough restrictions, because expression of disrespect for superiors is illegal. And doctors at private hospitals often suffer retaliation.

[http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045\(11\)70180-2/abstract](http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(11)70180-2/abstract) (accessed 27 June 2011)

THE BELGIAN Federal Health Institution KCE has reported that there is no scientific proof of clinical efficacy for homeopathy, and advises changing the country's legislation so that only physicians can become licensed homeopaths. The KCE is a

semi-governmental organisation that produces reports and studies to advise policymakers on healthcare and health insurance. In 2009 an estimated 6% of Belgians consulted a homeopath. "Homeopathy: State of the Arts in Belgium", published on 24 May, concludes, "there is no valid empirical proof of the efficacy of homeopathy (evidence-based medicine) beyond the placebo effect," and that homeopaths without a medical degree present a risk to the patient because the competencies required for treatment, "are by no means guaranteed, by either their training in homeopathy or their basic training".

Read the report in English on: [http://kce.fgov.be/index\\_en.aspx?SGREF=18910&CREF=19928](http://kce.fgov.be/index_en.aspx?SGREF=18910&CREF=19928) (accessed 27 June 2011)

A STUDY RECENTLY published in the new online journal *BMJ Open* has called on the General Medical Council to clarify how much time UK medical students' curricula should devote to complementary and alternative medicine. A survey among the deans of medical schools found wide variations in the quantity of, and approach to, teaching about CAM. "Current CAM education appears to exist primarily as a means of educating future doctors on the modalities that their patients may use or request," concludes author Kevin Smith, of the School of Contemporary Sciences, Abertay University, Dundee. "However, some forms of pedagogy arguably risk students assimilating CAM advocacy in an uncritical fashion."

<http://bmjopen.bmj.com/content/early/2011/06/08/bmjopen-2011-000074.short> (accessed 27 June 2011)

## THE LAWS OF LIBEL—A PERSONAL EXPERIENCE



*In 2007 a medical device manufacturer sued for defamation when a doctor publicly expressed his concerns over their clinical trials. The case has become a cause célèbre in the campaign for change in the UK libel laws. As his ordeal draws to a close the doctor, Peter Wilmshurst, has kindly agreed to share his experience with HealthWatch.*

**I WANT TO THANK members of Health Watch for their support during the three and a half years in which the three defamation actions (including both libel and slander) brought against me by NMT Medical have gone on. In particular, I wish to thank John Garrow for his tremendous support. I also want to thank the lawyers who have acted for me on a Conditional Fee Agreement ('no win, no fee'), particularly Mark Lewis and Alastair Wilson QC.**

The defamation cases ceased because NMT went into liquidation in April. It is unsatisfactory that the cases ended that way without a court hearing, but my concerns that information being published about the MIST Trial was incomplete and inaccurate have been vindicated because the journal in which the trial was originally published, *Circulation*, published a 700 word correction of the paper, a four page data supplement and a new version of the paper.

I do not believe these defamation cases were ever about protecting NMT's reputation. NMT's intentions were clear a year before they started the first defamation action in November 2007. In October 2006, after I expressed concerns about events in the MIST Trial, an executive of NMT sent me an email saying that they did not want me to speak about the trial and threatening that they would take action for breach of confidentiality if I spoke publicly. In February 2007, soon after I wrote a 14 page book chapter that devoted one page to the results of the MIST trial, NMT's English lawyer wrote to me threatening legal proceedings for breach of confidentiality and for an injunction. Such an action could not succeed because the results that I mentioned were already in the public domain—they were on NMT's own website. NMT wanted to silence me.

When NMT started the first defamation case, their share price was \$5, which compares with 10 cents in the week before going into liquidation. I presume that at the start they thought that they had enough money to use their wealth to bully me into silence. It is a scandal that wealthy companies can misuse the English libel laws to bully individuals in order to suppress freedom of speech and scientific discussion. I am concerned that the changes to the defamation laws will not prevent it being misused in the same way in the future.

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**"... the main flaw in the proposed reforms is that they do not address the high costs."**

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The main issues are legal costs and time wasted dealing with minor legal matters. Legal costs are much greater than damages awarded. For example, my lawyers had no doubt we would win, but they estimated that if we lost the amount of damages payable to NMT would be about £10,000. Such a sum was not a deterrent to fighting. However by the time NMT went bankrupt my legal costs were about £300,000. Cost lawyers estimated that if the case went to trial, costs on each side would be about £3.5 million, which would bankrupt me. In addition, the case would last six months in court, which would require me to give up work to fight it. Even if I won I would only recover about three-quarters of my costs, which would leave me £1 million out of pocket, bankrupt and homeless.

The case has taken most of my free time (evenings, weekends and most of my annual leave) for over three years. For example I had to take two weeks' annual leave to check my Defence submission. It

has cost me a lot of money and, at present, I do not know how much I will get back.

The financially expedient course would have been for me to back down as soon as NMT threatened action and say that I had no concerns about the clinical trial. Obviously that would have been unethical. If my lawyers had not agreed to a Conditional Fee Agreement I would have had to defend myself as a litigant in person: standing up in court myself to argue against the very expensive lawyers employed by NMT during the trial. The published annual reports of NMT show that they believed that I would have insufficient funding for continued legal representation. The overall effect is that a company with enough money to spend can force most people to back down and remain silent about issues of public concern, such as safety and efficacy of a medical device.

I am pleased that Parliament is currently amending the defamation laws. There are good elements in the proposals, such as a public interest defence, but that is far from ideal. For example, the Defamation Bill does not lay down clearly what sorts of statement are in the public interest. Instead it tries to determine whether something is in the public interest according to where it is said or written. My reading of the proposals suggest that a scientist might successfully use a public interest defence to defend a defamatory statement that has no public interest if he says it during a scientific meeting or in a peer reviewed journal, but he will find that he cannot use that defence for something clearly in the public interest if he said it on a radio programme or in a newspaper. That seems wrong.

I believe that amendments to reduce the ability of companies to sue individuals and to prevent libel tourism are good. In addition we need to make it much easier and quicker to strike out trivial or inappropriate cases, in particular when the purpose is to bully.

We need the laws to move into the age of the Internet. The abolition of the multiple publication rule will help, but we also need the law to protect Internet Service Providers from being sued because of a user's comment.

It is obvious that the defamation laws require reform but the main flaw in the proposed reforms is that they do not address the high costs. Some lawyers believe that some amendments will lead to additional costly hearings and lengthen cases, and so increase costs. As a result, I am concerned that wealthy individuals and companies will continue to use the laws to gag ordinary individuals. The greatest improvement would be to ensure that there is proportionality between damages and costs. Most of us believe that if defamed we should have some simple and cheap way of setting the record straight, but at present only the wealthy can afford to defend their reputations. Laws that only protect the interests of the most wealthy people or companies are unjust.

*Peter Wilmshurst  
Consultant in Cardiology  
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## psychotherapy

# DOES PSYCHOANALYSIS HAVE A PLACE IN THE SCIENCE MUSEUM?



Colin Brewer offers some reflections on evidence-based psychotherapy in the light of a new exhibition

**T**HERE WAS a little flurry of criticism among the usual suspects (i.e., people like HealthWatch members) about a recent Science Museum exhibition that implied support for psychoanalytical treatment, as opposed to simply noting its place in the history of psychotherapy, much as one might note the once-flourishing arts of trepanning or phrenology. Though crammed into a rather small space, it was prominently positioned at the entrance to the main exhibition hall. Brisk debates in *The Guardian*<sup>1</sup> and *New Scientist* followed its opening.

Anti-Freudians argued that since psychoanalysis was based on theories that were either immune to disconfirmation (and thus fundamentally unscientific) or had been tested and mostly disconfirmed, the museum shouldn't have given it space or should have made clear that its popularity in some quarters (as with homoeopathy) didn't mean that there was good evidence for its effectiveness. Freudians countered that psychoanalysis was still clinically relevant and could match the results of other talking treatments in some conditions. The museum were unhelpful when I contacted them, needing several reminders before replying (rather oddly) that, "The Science Museum has never set itself up as a gate-keeper deciding what is or isn't 'science'. As a museum, we have a wide ranging interest in many forms of scientific culture..."

Like all interventions, psychotherapies can be compared and evaluated. When designing controlled trials, blinding is more problematical for such therapies than it is for tablets, though less so than when comparing, say, medical with surgical treatments. However, psychoanalysis is a relic from the days before routine randomised controlled trials (RCTs). Its continued existence is reminiscent of the continued presence of bishops in Parliament, a symbol of something once powerful and influential but now much less so. Naturally, like the bishops, psychoanalysts (including the numerous schismatic sects) insist that they are still vital for the health of the nation.

It is true that in some comparative studies, psychoanalytical treatment gives similar results to those of its main competitor, cognitive-behavioural therapy (CBT). However, all psychotherapies have enormous placebo/non-specific components which (as with antidepressants) greatly exceed the specific effects of treatment. Most psychiatrists have encountered patients who thank you profusely at the end of a session during which they describe the problem as they see it and you do nothing except encourage them to talk. Patients respond non-specifically to being the subject of therapeutic attention and psychotherapy is one of the more obvious (and often gratifying) forms of attention. One of the best comparative studies of 'Freudian' psychotherapy vs CBT actually found a modest superiority for CBT but for me, the more important finding was that many patients in both groups experienced much of their subsequent improvement following the initial session, which was essentially diagnostic in focus rather than therapeutic.<sup>2</sup>

Two RCTs of psychotherapies in alcoholism—one old and British, one recent and American—had very similar outcomes. In Edwards *et al*'s (insufficiently) famous trial of 'treatment' vs a single session of simple 'advice' to cut down or stop drinking, there were similar and quite positive 12-month outcomes in both groups.<sup>3</sup> 'Project MATCH' was a very expensive multi-centre RCT of three conventional psychological interventions for various types of problem-drinker.<sup>4</sup> The results were awaited with great anxiety by the partisans of Alcoholics Anonymous, CBT and motivational interviewing but in the end, it was a case of 'all have won and all shall have prizes'. It is significant that when MATCH was designed in the

1990s, nobody thought that Freud-based therapies deserved a place. It's also worth noting that 10% of the subjects deteriorated during treatment. A later review of the results concluded that: "Untreated alcoholics in clinical trials [also] show significant improvement. Most of the improvement which is interpreted [in MATCH] as treatment effect is not due to treatment. Part of the remainder appears to be due to selection effects." Other studies repeatedly show that, with the possible exception of CBT, which involves specific and quantifiable techniques, there is no difference in outcomes between trained and untrained counsellors or therapists.

Psychoanalysis involves many assumptions (mostly untestable) about human nature and the 'structure' of the psyche: CBT makes relatively few, mostly testable. If Freudianism's venerability is supposed to be a plus-factor, perhaps we should go back even further to Occam, whose trusty Razor warns us against complex, assumption-rich theories like Freud's. Another problem of evaluating psychotherapies is that inter-therapist variability is a major confounder. To some extent, this is true of all treatments (experienced surgeons are better than tyros) but in psychotherapies, the therapist largely *is* the treatment. Unsurprisingly, four-fold inter-therapist variations in outcome for the same therapy are not uncommon<sup>5</sup> (the paper quoted here refers specifically to psychotherapy in addictions, though it is probably true in general), whereas myxoedema responds to thyroxine regardless of the prescriber's bedside manner.

**T**HE EXHIBITION was called 'Psychoanalysis. The unconscious in everyday life'. The museum wouldn't give me contact details for the curator but she wasn't difficult to find and was happy to talk with me. Dr Caterina Albano is a cultural historian at St Martin's College of Art and the exhibition was the museum's idea, not hers. She disclaims any particular views about psychoanalysis as a treatment, regarding it rather as one way of looking at life and art. She thus displayed items by trendy ceramicist Grayson Perry but also included toys devised by psychoanalysts for 'play therapy' with children. This gave a distinctly therapeutic air to the exhibition that was arguably unfortunate. I doubt very much that psychoanalysis would have entered and influenced Western thought as much as it did (and clearly still does in non-scientific circles) if it hadn't done so by using Freud's status as a physician who claimed powerful individual and social curative properties for his invention. That claim has no serious evidence-base.

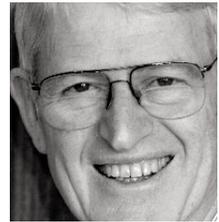
Psychoanalysis began life as a psychological treatment, once so prominent that Baroness Wootton famously claimed in the 1960s, "Today Freud and Marx might fairly compete for the title to the biggest popular success since Jesus Christ; and Freud, I think, would win."<sup>6</sup> That now seems doubtful. Freud's Collected Works have been discreetly moved by their publisher from 'psychology' to 'philosophy'. Philosophers don't do RCTs. The worst of them just try to impose their philosophy on the rest of us. People who disagreed with Freud were accused of showing

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# HOMEOPATHY AND ITS USE IN DENTISTRY

*Cures that cannot be substantiated, and claims to be more caring—Keith Isaacson shares his doubts*

**I**T MAY come as a surprise to most people that there are a number of dentists in the United Kingdom that use homeopathy in their surgeries. David Shaw, Glasgow University's lecturer in ethics, recently published an article in the *British Dental Journal*,<sup>1</sup> from which much information in this article has been abridged with permission. It describes how homeopathic dentistry is being promoted. Statements being made by several organisations in favour of the use of homeopathy in dentistry may not be entirely ethical.



As HealthWatch members will know, there is no evidence for the efficacy of homeopathy beyond its value as a placebo. Even the Society of Homoeopaths, one of the main organisations representing UK practitioners, admits that, "science has not been able to explain the mechanism of action of ultra high dilutions in the body".<sup>2</sup>

Dr Shaw's article examines statements made with respect to dentistry by the different organisations representing homeopathy in the UK. The Faculty of Homeopathy, which claims to ensure, "the highest standards in the education, training and practice of homeopathy" surprisingly carries no ethical code of practice on its website (it mentions its part in the creation of, "a European code of professional conduct" but does not display or link to that code). But their 2011 Dental Guidelines list conditions "amenable to treatment" with homeopathy, including haemorrhage and dental abscesses.

The British Homoeopathic Association's website,<sup>4</sup> in its explanation of dental homeopathy, lists conditions that "patients find" respond well to homeopathic treatment, "pain, swelling, bruising, dental anxiety, nausea, tooth sensitivity, jaw cramping, teething in babies, neuralgia, toothache, bleeding, infection, ulcers and cold sores." No evidence is cited for these claims. An article on the same site by the Faculty of Homeopathy's Dental Dean, Peter Darby, states, "Several clinical trials and observational studies have demonstrated the therapeutic effects of Arnica in the reduction of post-extraction complications."<sup>5</sup> It would no doubt be helpful to his readers to learn that subsequent work has invalidated these findings, attributing them to errors in trial design,<sup>6</sup> however this information is not mentioned.

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**"The BHDA website offers six reasons to visit a homeopathic dentist, of which four make medical claims, including one which says that there are remedies, 'which cure ulcers and cold sores and many more.'"**

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Whilst homeopathic treatment may not directly harm the patient's life, if he or she has to seek further treatment after a failed attempt to stop pain or bleeding which could have been treated effectively by conventional means, then the patient has indeed been harmed. Another article from the BHA website states, "Homeopathically-trained dentists are much more than drillers, fillers and billers. We can even hope to improve the overall health of the patient and not just the dental condition presented to us."<sup>7</sup> Surely conventionally trained dentists aim to do that as well? A further recommendation is, "you should always go to a dentist if the pain is severe and preferably one who can prescribe or recommend homeopathy". Does this mean that homeopathic dentists are better able to treat pain than conventionally trained ones? The article even finishes with the possibly harmful advice that non-fluoride toothpaste is better than fluoridated, as well as the inexplicable assertion that, "some people believe the peppermint in conventional toothpastes antidotes homeopathic medicine.

The only UK organisation specifically for dentists is the British Homoeopathic Dental Association, whose website<sup>8</sup> includes a listing of its 73 members, all of whom have a recognised qualification in dentistry and an interest in homeopathy. The BHDA makes some

very forthright claims on their website. "Do you think that your present dentist is really kind and caring? Homeopathy is a very caring discipline. Try a member of the BHDA and experience a really kind, considerate, holistic and caring approach to dental treatment." Is it entirely professional to imply that non-homeopathic dentists are not really kind and caring? Or is this, as Ben Goldacre has pointed out, an example of that routine feature of the homeopathy industry's marketing strategy: to denigrate mainstream medicine? The BHDA website offers six reasons to visit a homeopathic dentist, of which four make medical claims including one which says that there are remedies, "which cure ulcers and cold sores and many more."

No references are provided. There is, sadly for afflicted visitors to this website, no cure for the herpes simplex virus which causes cold sores.

A whole raft of laws, guidelines and official advice could be invoked here. The claims that homeopathic remedies are able to treat medical conditions breach The Consumer Protection from Unfair Trading Regulations 2008 which specifically forbid false claims that a product can cure disease.<sup>10</sup> The Code of Advertising Practice, which in March 2011 widened its remit to encompass marketing material on websites, states that "marketing communications should be legal, decent, honest and truthful." Even the Society of Homeopaths requires its members to adhere to the Code of Advertising Practice, and says clearly that, "No promise of cure, either implicit or explicit, should be made of any named disease."<sup>11</sup>

The World Health Organisation recently warned against using homeopathy to treat serious diseases.<sup>12</sup> Dental abscesses can lead to serious complications if not treated correctly. And what of the General Dental Council Standards for Dental Professionals? These state that dentists must, "Provide a good standard of care based on available up-to-date evidence and reliable guidance."<sup>13</sup>

David Shaw's article did not go unnoticed. A response appeared in April entitled, "Homeopathy and its ethical use in dentistry" by Sarah Eames and Peter Darby<sup>14</sup> of the Faculty of Homeopathy which blamed the paucity of research evidence on the lack of commercial interest in funding trials; and asserted that because the scientific study of ultra-molecular dilutions is in its infancy there is no complete explanation of how the medicines work. They claim instead a wealth of case histories suggesting consistent positive results from use of homeopathic medicines (no references given).

I started drafting a letter to the journal to propose a randomised controlled trial on a condition like *lichen planus*, in which half the patients would be given homeopathic medicine and the other half diluted water which had been stirred but not shaken. However even this would be unethical: according to a recent article by Kevin Smith of Abertay University, "Because it is inherently ineffective, homeopathy cannot be ethically neutral. It follows that the purchase, deployment or promotion of homeopathy is morally unacceptable."<sup>15</sup> I re-wrote my letter with a succinct quote from the summary of Dr Smith's article, "Homeopathy is ethically unacceptable and ought to be actively rejected by healthcare professionals."

Keith Isaacson  
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North Hampshire Hospital, Basingstoke

...see page 6 for references to this article

## news

# A SLAPP SUIT FOR AUSTRALIAN WHISTLEBLOWER

**A**N AUSTRALIAN public health advocate has become one of the latest targets of what has been coined as a “SLAPP” suit—a strategic lawsuit against public participation, according to campaign group Australian Skeptics.<sup>1</sup> Dr Ken Harvey has been fighting an \$800,000 claim for damages made against him by the Sydney-based weight loss product manufacturer SensaSlim.

Dr Harvey, of Melbourne’s LaTrobe University, complained earlier this year to the country’s Therapeutic Goods Advertising Complaints Resolution Panel (TGA) about claims made on the manufacturer’s website that SensaSlim could, “desensitise taste buds and reduce hunger pains”.

Before his complaint could be properly considered, however, SensaSlim launched a libel suit against Harvey alleging that his complaint was defamatory. The court action effectively stalled the processing of the TGA complaint, and the SensaSlim website continued to claim that the product’s “potent active ingredients enter the blood stream and naturally suppress the appetite”.<sup>2</sup>

As this newsletter was about to go to print, Ken Harvey e-mailed HealthWatch to say that the company’s lawyers had withdrawn from the case, and SensaSlim was in liquidation. Harvey’s lawyers are to apply to have the case struck out and costs awarded. He told us, “However, it is very doubtful if any money from the liquidator will be available to pay the costs awarded! Regardless, the case has

highlighted some fundamental flaws in Australian regulation concerning complementary medicines and the promotion of therapeutic goods which have been the subject of many submissions to recent government enquires.” Australian Skeptics is running a campaign to raise funds to support Ken Harvey.

At the time of printing, SensaSlim website is still running. Its homepage features Dr Matthew Capehorn, Clinical Director of The National Obesity Forum (UK), though Dr Capehorn has attempted to distance himself from the company, reportedly because promised proof of clinical trial results was not forthcoming.<sup>3</sup>

Mandy Payne, with thanks to Loretta Marron

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1. <http://www.skeptics.com.au/> (accessed 27 June 2011).
2. <http://www.sensaslim.com.au/> (accessed 4 July 2011).
3. <http://www.choice.com.au/reviews-and-tests/food-and-health/diet-and-exercise/weight-loss/sensaslim-sues-ken-harvey.aspx> (accessed 27 June 2011).

## Does psychoanalysis have a place in the Science Museum? ... continued from page 5

‘resistance’. Communists once referred to contrary views as ‘false consciousness’ or ‘counter-revolutionary thought’. Thank goodness both philosophies have been put in their place.

None of this should induce therapeutic nihilism. People usually feel better after talking (and listening) therapies but that is mainly because all clinicians—even insensitive ones—are walking placebos, whether we like it or not. Nothing wrong with that, as long as we remember that placebos are supposed to help patients feel better. They are not supposed to help doctors feel that they have developed a specifically effective treatment when they haven’t.

Colin Brewer

Research Director, The Stapleford Centre, London

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# PROGRESS IN PUBLIC UNDERSTANDING OF HEALTH RESEARCH

Ten years on: there has been significant progress since Iain Chalmers first convened a conference to explore ways to help the public gain a better understanding of health research. Nick Ross reports from the latest meeting of minds.



**H**OW CAN WE know what's good for us? How can we judge a health article in the daily newspaper? How can we even be sure that our doctor, nurse or midwife is giving the best advice? These are hardly trivial questions. Our health, and maybe our lives, depend on getting the answers right.

Tragically, people often get the answers wrong. Indeed HealthWatch can trace its origins to a breast cancer clinic in London where the oncologist Prof Michael Baum was confronted with a steady stream of patients who had shunned conventional treatment in favour of quackery or been subjected to unnecessarily mutilating procedures by surgeons whose concept of best treatment was based on anecdote and personal experience.

Matters have improved greatly since then and the concept of evidence-based medicine has been ushered centre-stage. Nonetheless HealthWatch still sometimes has an uphill struggle persuading the medical professions to embrace scientific methodologies. Nursing and midwifery courses are mostly silent on how to tell good health information from bad and when I lobbied those who set the curriculum I was told that nurses did not need to understand scientific methodology. The result is that qualified nurses and midwives are frequently as ignorant as their patients. Each year HealthWatch runs a competition to test how well young clinicians grasp the basics of testing evidence and entries from nurses and midwives remain sparse, disappointing and sometimes dire. And while almost all doctors now embrace the need for medical research, including double-blinded randomised trials, continued support by many physicians for complementary therapies suggest it is still possible to qualify and practice medicine with little clear understanding of how important it is to guard against the twin poisons of knowledge: bias and chance.

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**"When I lobbied those who set the curriculum I was told that nurses did not need to understand scientific methodology."**

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The lay press continues to be supportive in principle of medical research but still has a tendency to project investigators either as miracle-workers or as dangerous boffins. Concepts like randomisation are rarely mentioned or explained with the result that many people think comparative research is somehow unethical and bridle at the arbitrary allocation of patients to different treatment arms.<sup>1</sup>

Nor is the scientific community doing as much as it might to address the issue. Within medicine initiatives like the Cochrane Collaboration and James Lind Libraries have helped cement the need for good protocols and popularised pooling of data through meta-analysis. Outside the profession groups like Sense About Science (and particularly the Voice of Young Scientists) have been spreading the gospel of fair testing far more effectively than previous rather stodgier educational efforts like the Royal Society's and RI's Committee on the Public Understanding of Science.

But progress is patchy. For example, the Science Museum has never had an exhibition which explains how science is a methodol-

ogy rather than a collection of facts or artefacts. Even the Wellcome Trust's recent event on "Quacks and Cures" gave visitors no guidance on how to distinguish between quack remedies and effective treatments.

Ten years ago a group including Professor Sir Iain Chalmers (of the Cochrane and James Lind Library, and 2009 HealthWatch Awardwinner) convened a conference to explore ways of improving public understanding of health research. One of its many outcomes was to coin the term 'fair tests' instead of the geek terminology 'RCTs'; another was the hugely successful book *Testing Treatments*.<sup>2</sup> This April, a decade on and still facing a challenging inertia, there was a second, bigger gathering, this time over two bright sunny days at Kellogg College Oxford and drawing 40 participants from around the world.

Again there was a plethora of other ideas, among them that all concerned with evidence-based medicine should be proactive in ensuring Wikipedia's medical entries are factually accurate and give a fair assessment of the research that led to the conclusions. This is something HealthWatch members can actively engage with and is plainly important. After all, patients and their carers frequently consult the web for disease-specific information and even medical students get much of their information from Wikipedia. Thus contributors should strike a balance between giving enough information to explain complex concepts, especially, and making the content too dense for lay readers to engage with.

The most direct and emphatic outcome was for a new website dealing with quack science, to be called something along the lines of *certifiedbullshit.com*, targeting—aggressively if needs be—bad science and pseudoscience wherever it is published. The Wellcome Trust is to be approached to provide funds for a 'proof of concept' website and conference participants agreed to stay in touch to collaborate on its future.

Watch this space.

Nick Ross

Broadcaster and journalist, President of HealthWatch

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## last word

# TACKLING THE PROBLEMS THAT MODERN MEDICINE CAN'T SOLVE



**IT IS COMMONPLACE for sceptics to make a concession to complementary and alternative therapists that whilst they may use ineffective 'treatments', the therapists themselves do at least have an interpersonal touch which makes people feel better, and from which scientific medicine can learn.**

It seems to me to be irrefutable that the modern technological approach to medicine can be guilty of treating people as objects or diseases, and that we need sometimes to remind ourselves that it is people who have illnesses and who need caring for. However, I will argue now that we should not be looking to the alternativists to obtain these skills.

As a general practice surgery we have managed to draw in resources from the local community to start a number of community groups. We have a reading group, and a gardening group, and we are looking into arts and craft groups.

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**"We, the GP's, are probably the only institution locally that a substantial proportion of the local population makes contact with each year."**

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I would be the first to say that I am not trained in such things, and that I as a trained GP should stick with General Practice. However, it is the case that our local community lacks a focus. The church is not the hub it used to be, with only 2% of the national population attending regularly. It just happens that we are probably the only institution locally that a substantial proportion of the local population make contact with each year.

Our groups are not particularly well attended, but some patients do seem to be engaging and finding them helpful. The idea is that we have some patients who are isolated, and lonely, and who possibly watch too much TV, who might end up coming to their GP because they have little other focus in life, and become excessively

concerned with relatively minor symptoms. Rather than giving another prescription for paracetamol for their recurrent headache, we can redirect them to do a spot of gardening.

Now this is a tentative small step, but it is at least recognising the problem—that our society is becoming increasingly dependent on medicines to solve problems that medicine can't solve. Such people, time-consuming and often problematical for GP's whose frustration sometimes drives them to apply the unfortunate label, "heartsink patients", are a gift to alternative therapists everywhere. Their very inability to address their own problems and instead to seek help from therapists is what makes them particularly suggestible and open to the placebo effect and a little bit of attention from someone. But this short term 'buzz' of attention lacks depth and roots (since we are talking about gardening). It is enough of a fix to get them back again in a few weeks like a drug addict, but it is likely to anaesthetise people against seeking out solutions with greater depth.

Yes, they might like a caring chat with their clinician, but how much better to be in a community meeting other people, sharing hobbies, sharing ideas, thinking, reading, talking, creating, and learning to cope with the various challenges of life as a shared endeavour.

So I agree. A bit of attention from a doctor, real or alternative, will make people feel happier for a time. But I think this might just be a bad thing in the long run.

*James May*

*GP Principal, London and chairman of HealthWatch*

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