When Professor Brian Schmidt won the 2011 Nobel Prize for Physics, Australian universities and governments were quick to bask in reflected glory and proclaim themselves part of the great Australian scientific legacy. What a pity, then, that both sectors should systematically betray it. Many Australian Universities now teach pseudoscientific alternative health courses as though they were scientific. The Australian Skeptics recently found more than a third of Australia's 39 universities offered alternative healthcare courses that are not evidence-based.1,2

In Britain, such courses are already starting to disappear from universities thanks to poor recruitment and growing scrutiny of public funding for scientifically dubious practices. In 2007, UCAS listed 45 different BSc degree possibilities across 16 UK universities in subjects that nearly all mainstream scientists would call pseudo-science. Today there are only 24.3 Degrees in homeopathy, naturopathy and “nutritional therapy”, reflexology and aromatherapy have vanished altogether. Derby University has said that as of 2012 it is shutting down its complementary medicine department. The University of Westminster, which used to be the country’s leader of alternative medicine degrees, is no longer taking on new students in this area of study for the fall 2012 semester. And as of last year, students at Salford University in Manchester may no longer take a Bachelor of Science degree in homeopathy, Chinese medicine or acupuncture.

"we believed Australian scientists should care when their universities were teaching non-science under a scientific banner. We soon found that many—and not just in Australia—already did"

Last December I was one of five concerned people who together formed Friends of Science In Medicine (FSM), “to reverse the trend which sees government funded tertiary institutions offering courses in the health care sciences that are not underpinned by convincing scientific evidence”. My co-founders were John Dwyer, founder of the Australian Health Care Reform Alliance & emeritus professor at University of New South Wales; Marcello Costa, professor of Neurophysiology, Department of Physiology at Flinders University; Alastair MacLennan, professor and head of the Discipline of Obstetrics & Gynaecology, University of Adelaide; and consumer advocate Loretta Marron, whose media campaigns against dangerous health practices have made her a household name in Australia.4

We acted because we believed Australian scientists should care when their universities were teaching non-science under a scientific banner. We soon found that many—and not just in Australia—already did. Within a month more than 400 prominent scientists, academics, consumer advocates and organisations had joined us. You can join, too, by e-mailing us at info@scienceinmedicine.org.au We are also arguing that non-evidence-based alternative treatments should not be eligible for rebates from Australian medical insurance providers, a practice that is already under review in European countries.

Our first move, then as a group of 35 doctors, scientists and clinical academics, was to write a letter to the science deans at Central Queensland University asking them to reconsider their decision to offer a Bachelor of Science Degree (Chiropractic) from 2012. On 23rd January we sent letters to all Australian vice-chancellors calling for a change in university policy. These activities sparked extensive media coverage over here including features in The Australian, The Sunday Mail, Adelaide Now, The Sydney Morning Herald, The Medical Journal of Australia and the Australian academic blog website The Conversation which, on...continued on page 3
news

THEATRE ACTS ON CALL FOR EVIDENCE

A SHORT CAMPAIGN initiated by HealthWatch and supporters has managed to switch the beneficiary of a fundraising event from a charity promoting unproven treatments to one which gives practical help to the homeless.

A HealthWatch member noticed a charity night was scheduled for 14th April at London’s Bloomsbury theatre in aid of “Yes To Life: Your Options for Cancer”. This charity offers cancer patients information on integrative medicine, practitioners and suppliers. Though the intentions of the charity are clearly good, the treatments promoted range from the ineffective to the dangerous, and include for example the discredited Gerson Therapy, whose coffee enemas have, according to Cancer Research UK,* been linked to “serious infections, dehydration, constipation, colitis (inflammation of the colon), and electrolyte imbalances.” While overlooking effective orthodox medical treatments, the “Yes To Life” website gives contact details for overseas clinics supplying costly controversial therapies. Its medical supporters include many previously associated with Prince Charles’ now-defunct Foundation for Integrated Health.

The charity fundraising night will be a live show by Howard Marks, ex-marijuana-smuggler, bestselling author and the subject of the 2010 film, Mr Nice, who talks entertainingly about his experiences. It is not known whether Mr Marks knew the charity promoted unproven treatments, but it seems the Bloomsbury and the organisers, The Charity Fundraiser, did not. The Bloomsbury has in the past hosted a number of sceptical events, including Robin Ince’s Nine Lessons, and performances by Brian Cox, Richard Dawkins, Ben Goldacre and Simon Singh.

Susan Bewley, Michael Baum and David Colquhoun were among those who sent e-mails to the theatre and the organisers to highlight their concerns. Peter Cadley, director of the Bloomsbury (www.thebloomsbury.com), and Jeremy Banks of The Charity Fundraiser (www.thecharityfundraiser.co.uk) both responded swiftly by changing the event’s beneficiary.

The event went ahead but all funds raised will now go to the Beyond Food Foundation, a charity that helps people who have been homeless and unemployed find work in cooking and catering. Tickets are £16.

Reference
*http://cancerhelp.cancerresearchuk.org/about-cancer/treatment/complementary-alternative/therapies/gerson-therapy

NEWS IN BRIEF

A STUDY by HealthWatch volunteers has just been published in the Medico-Legal Journal. “Spurious Claims for Health-care Products: An Experimental Approach to Evaluating Current UK Legislation and its Implementation” by Les Rose, Paul Posadzki and Edzard Ernst highlights the difficulties in bringing about action against manufacturers making false claims for products sold in the UK. The paper is available online at http://milj.rsmjournals.com/content/80/1/13.abstract

CALL FOR MEMBER PARTICIPATION HealthWatch aims to take an active role in support of evidence based health care. The publication of the above study on the limitations of consumer legislation in preventing false claims for health care products, is just the start. Other projects are planned, and we need your help.

DOCTORS HAVE been instructed by the General Medical Council never to sign a contract with their employer containing a “gagging clause” that would prevent them from revealing sub-standard practice. The new guidance Raising and acting on concerns about patient safety, which came into effect on 12 March, seeks to encourage whistleblowing, and stipulates that doctors have a duty to act when they believe patient safety is at risk. Last year, it was revealed that hospital doctors were routinely required to sign confidentiality agreements if they quit their job in a dispute with their employing NHS trust. http://www.guardian.co.uk/society/2012/jan/26/nhs-health

The MHRA is proposing to scrap its approval scheme for homeopathy, as part of the government’s “Medicine’s Red Tape Challenge”. The National Rules Scheme for homeopathic treatments, introduced by the MHRA in 2006, enables registration of indications for the treatment of minor conditions. Yet in the last five and a half years only one product—Nelson’s Arnica Arnica 30c pillules—has been registered. The Red Tape Challenge asks whether existing regulations really provide the intended protections. Rules on traditional herbal medicines and the regulation of clinical trials may be for the axe, too. The date for submitting views is now passed, but you can read the comments of those who took part in the debates on: http://www.redtapechallenge.cabi.netoffice.gov.uk/themehome/medicine/

AN ELDERLY CANCER patient is suing the Texas doctor Stanislav Burzynski, who is known in the UK because charities here raise money to send children to receive his costly unproven cancer treatments (see HealthWatch Newsletter Issue 84). Lola Quinlan of Florida, who has stage IV cancer, has claimed the doctor and his companies defrauded her of $100,000 by persuading her to undergo a proprietary cancer treatment without being informed it, “was actually a clinical trial,” and charging $500 per pill for drugs she could buy elsewhere for a fraction of that price. Her lawyers say the treatments were wholly ineffective and caused even more damage to Ms. Quinlan’s body.

SIX OUT OF 14 UK “nutritional therapists” gave dangerous advice in a survey by Which? magazine. Five undercover researchers who made 15 visits to 14 “nutritional therapists” in the United Kingdom received inappropriate advice from all of them. Only one consultation of the 15 was deemed a borderline pass by the Consumer’s Association medical experts. One researcher, posing as a breast cancer patient, was advised to delay medically-advised radiation therapy and instead follow a no-sugar diet to drive away the cancer. Several therapists used non-evidence-based “diagnostic” tests such as iridology, and twelve visits resulted in recommendations for costly dietary supplement regimens.

Which? Feb 2012, pp 58-60

http://www.guardian.co.uk/society/2012/jan/26/nhs-health

http://www.pulsetoday.co.uk/newsarticle-content/-/article_display_list/13623892/mhra-poised-to-scrap-controversial-approval-scheme-for-homeopathy

http://www.courthousenews.com/2012/01/19/43165.htm
HEALTHWATCH’S STUDENT Prize Competition is ten years old and last year attracted the highest number of entrants so far. This important award, now generously sponsored by the Medico-Legal Society, gives UK medical and nursing students the chance to demonstrate their skills in critically appraising clinical trial protocols and so assessing the validity of research.

Entries are invited to appraise four single-page hypothetical research protocols and to rank them according to which are most likely to provide a reliable answer to the stated aim of the trial. The protocols contain varying degrees of scientific, methodological and ethical flaws which the students are expected to identify and comment upon in 600 words.

The 2011 competition’s experimental protocols were, “Preventing obesity in children—to determine if extra physical activity and dietary intervention leads to sustained avoidance of obesity in children”; “Cherry extract for the treatment of gout”; “TENS for pain relief in labour—to determine if Transcutaneous Electrical Nerve Stimulation (TENS) is effective in relieving pain in labour”; and, “Does sleeve length affect bacterial contamination of doctors’ wrists”.

The competition is run by Professor David Bender, who promotes it to universities and medical schools through Student BMJ and university electronic communications, and processes the entries. Professor John Garrow continues as scientific advisor and arbiter in cases of judges disagreeing.

Last year’s total of 130 entries, despite being the best response in the history of the competition, is still only a tiny figure out of the current 6000 medical students in the UK. Of the total entries, 62 had ranked the protocols in the correct order. As always, the judges paid particular attention to whether students identified protocol design weaknesses, such as absence of, or inappropriate control group, absence of patient/or assessor blinding, and ethical issues. The judges assess the entries independently of each other with the aid of a 12-point check-list and then compare their results to reach agreement. It was encouraging that those who ranked the protocols in the correct order, generally showed a good level of understanding of clinical trial design, and made thoughtful and valid suggestions on how the protocols could be improved. The judges were impressed by students who gave well articulated explanations, rather than merely having ticked boxes in “clinical trial design tables” obtained from the internet. Some students were confused as to what constitutes valid patient consent—in the childhood obesity protocol, some believed the headteachers’ agreement to their schools taking part was sufficient. Nevertheless, compared to earlier years, this year’s students paid more attention to ethical aspects and more often commented correctly on absence of ethics committee clearance or valid consent clauses in specific protocols.

This welcome observation suggests that medical and nursing colleges are now paying more attention to the teaching of clinical research methodologies.

As in earlier years, a poor response from nursing students (only five entries) was disappointing, and active steps by the HealthWatch committee to generate interest among the nursing community have so far not been successful. New approaches are now being explored. But interestingly, of the five nursing students that took part, four (80%) had placed the protocols in the correct order, one of whom gave sufficiently well-argued reasons for her choice to merit a commendation.

An interesting observation was a 29% increase in the number of entries from Birmingham Medical School, the only new medical school to participate in the competition. This welcome observation suggests that medical and nursing colleges are now paying more attention to the teaching of clinical research methodologies.

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Wallis Bounds, Research Co-ordinator (retired) Margaret Pyke Centre, University College London

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FRIENDS OF EVIDENCE GO GLOBAL

31st January, published a lengthy interview feature between Dr Marcello Costa and the UK science writer Simon Singh. Thanks to the publicity and word-of-mouth, membership of FFSM is now well over 600.

While FFSM has started with the universities, to draw attention to those who are offering blatant pseudoscience as though it were science, we also intend to approach the federal government, which currently funds universities that offer non-evidence-based treatments among those eligible for a refund, despite clear evidence that they are ineffective.

The teaching of pseudoscience as science in our universities not only confuses the issue as to what real science is and does; it is dangerous because it gives unproven practices undeserved credibility. Here in Australia, as elsewhere, CAM proponents lobby aggressively for a bigger role in primary health care. The self-regulated Chiropractors’ Association of Australia (CAA), wants Chiropractic to become the major primary care discipline in the country. They have already successfully lobbied the government to win the right to call themselves “doctors”. Real medical doctors are in very short supply in many parts of Australia, waiting lists are long and federal funding for their work is being cut. Now, when a rural patient goes to see the “doctor”, what kind of doctor will they see?

Rob Morrison
Professorial Fellow
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References
regulatory affairs

THE LICENSING OF MEDICAL DEVICES

MEDICAL DEVICES have attracted much media attention in recent months on account of safety issues related to specific devices, such as the PIP silicone breast implant, and metal-on-metal hip prostheses. Questions have been raised as to how such products are licensed for use in the UK, and Peter Wilmshurst, consultant cardiologist and winner of the 2003 HealthWatch Award, recently described the current situation in a *British Medical Journal* editorial as “unsatisfactory, unscientific, and in need of major overhaul”.

What follows is a brief overview of the regulatory approval process for medical devices.

In Europe, all medical devices are subject to the European Medical Devices Directive (MDD), whose main purpose is to allow the free trade of such devices throughout the EU and to protect patient safety. It sets out ‘Essential Requirements’ to ensure that a device achieves its intended purpose and does not compromise the health or safety of the patient, healthcare provider or anyone else. Three European Directives have been implemented into UK legislation by the Medical Devices Regulations 2002 (with amendments in a more recent Directive 2007/47/EC). These are the Active Implantable Medical Devices Directive (90/385/EEC), the Medical Devices Directive (93/42/EEC) (as amended in Directives 2000/70 and 2001/104 on medical devices incorporating stable derivatives of human blood or human plasma) and the In Vitro Diagnostic Medical Devices Directive (98/79/EC).

Each member country designates a ‘Competent Authority’ (in the UK this is the Medicines and Healthcare products Regulatory Authority, or MHRA) to implement and enforce the Regulations and to set up systems for the reporting of adverse events and alert healthcare providers to possible problems. However unlike medicines, which are licensed directly by the MHRA, the actual approval of medical devices is by private sector organisations called ‘Notified Bodies’ (see below).

### Classification of devices

The Medical Devices Directive 93/42/EEC covers an extremely wide range of products including first aid bandages, spectacles, hip prostheses, heart valves, contraceptive devices, X-ray equipment, prostheses, heart valves, contraceptive devices, X-ray equipment, and breast implants, to name but a few. Their classification will depend on a series of factors, such as, how long the device is intended to be in continuous use, whether or not the device is invasive or surgically invasive, and whether or not the device contains a medicinal substance with actions ancillary to that of the device itself.

It is down to the manufacturer to assign the product, using MDD classification rules, to a class from I to III. A higher level represents a greater risk and calls for a stricter assessment to be applied.

### Product Registration and the granting of the CE Mark

The CE Mark (CE = Conformité Européenne) is a legal requirement for devices marketed in the European Union (EU). In the case of Class I devices, a manufacturer’s statement of “self-declaration” that his product complies with all the relevant Essential Requirements of the Directive is enough to register the product with any European country’s Competent Authority and receive the CE mark (manufacturers of sterile products and measuring devices need additional certification on aspects of sterility and metrology.)

Devices in Classes IIa, IIb, and III must be submitted to a Notified Body for conformity assessment, which applies controls whose strictness depend on the level of risk to health and safety. Once certification is received from the Notified Body, the manufacturer may apply the CE Mark and place the device on the market.

Note that a manufacturer can choose which EU country to register his device in; it does not have to be the country where he is based.

### Notified Bodies

Notified Bodies are private for-profit certification organisations, chosen by the Competent Authority of a Member State (MHRA in the UK) to carry out the conformity assessments described in the Directives, and issue the CE Mark. They are selected for their impartiality and relevant expertise, and periodically audited to ensure they continue to meet the required standards. Notified Bodies are staffed largely by administrators, but can bring in external experts as required and delegate some of its tasks to subcontractors, such as testing laboratories or other specialists, but the notified Body must retain the final and overall responsibility. They might assess a manufacturer’s quality system and the full design dossier; type examination; verification (unit or batch testing of devices); and a company’s production and product quality assurance records and procedures. Clinical data, if required at all (e.g., for specific Class III devices), may involve merely a review of the relevant scientific literature or clinical trial data for an equivalent device, rather than the device being assessed for approval (see new Directive 2007/47/EC).

There are currently 74 separate Notified Bodies in the EU (including six in the UK) authorized to approve medical devices. They are spread over 25 countries, and manufacturers can apply to any one of these Bodies for CE Marking.

### Post-marketing Medical Device Vigilance

The Directive has guidelines on vigilance systems which, though...continued on page 7
A SOURCE OF HOPE WITH AN EVIDENCE BASE

Nick Ross recently came across a new online service whereby patients can search for clinical trials of new treatments for their condition. HealthWatch welcomes developments which enable patients to get involved in evidence, and this simple idea seems to provide quality information and support research. Dr Claire Nolan explains.

Y O U R T R E A T M E N T C H O I C E S is a website where patients can search for, watch and ask about clinical trials taking place locally or nationally. It is free for patients and independent of any pharmaceutical company or contract research organization that runs trials on behalf of trial sponsors. Managed and operated by Tomorrows Medicines, a start up company based at Daresbury Science and Innovation Park in Cheshire, UK, YourTreatmentChoices facilitates a dialogue between patients who want clinical trial options and clinical researchers responsible for them.

The need for such information is clear from patient users responding to a recent site survey. Typical of their comments were, “When first diagnosed with cancer, I couldn’t get the information I needed, and clinical trials were never mentioned. I am very pleased I have found this site”; and, “I have some knowledge of clinical trials from my own research using the Internet and have experience of not being referred for a clinical trial by my consultant, maybe he didn’t know about it, or maybe he didn’t think about referring me?”

I developed the patient site with my brother and fellow Tomorrows Medicines’ co-founder, Christopher Nolan—between us we have more than 35 years combined experience in the pharmaceutical and IT industry. We had become aware of patients less than 40 years of age with terminal cancer who were offered quality of life care alone with no clinical trial options at all. Tomorrows Medicines was awarded a grant by the Technology Strategy Board, the UK Innovation agency, sponsored by the Department of Business Innovation and Skills (BIS) to establish the interactive clinical trials patient portal as a commercial entity.

Since November 2011 when the beta site was made available, thousands of patients in the UK alone have searched for clinical trials for more than 190 conditions, the most popular being breast cancer and lung cancer. Globally, the site provides access to more than 40,000 actively recruiting and ethically approved trials in more than 190 countries. To date it has been used by patients from 25 different countries. In a survey of 80 cancer patients, 83% said they would use the site to find and learn about local and regional clinical trials. Eighty per cent would use the private messaging system to make contact with the clinical trial team and 77% say they are likely to consider participating in a clinical trial using the services provided by YourTreatmentChoices.com.

...a way to connect directly with patients, raise awareness of ongoing research and help with recruitment.

Patients say they will use the site to look for relevant local trials they can take part in even if they are not at their specific hospital. “Direct access to the trial doctor is an excellent facility. I really like the site and like that you can communicate directly with a health professional with respect to trials in my location”. As a source of information and trials, some physicians themselves believe the site should be made more widely known to patients. “I would find it helpful to advertise YourTreatmentChoices.com to my patients” one physician suggested, whilst another said, “I feel that all clinicians considering placing patients on a clinical trial should provide a link or information on this web site.” Professor Mason, a Clinical Oncologist at Cardiff University explains via a video on the site how patients can send enquiries to clinical researchers and how clinical researchers can interact with patients. The doctor responsible for the patients’ care is an essential component of the communication triangle.

Academic organizations, government bodies and research networks are looking at the new patient portal as a way to connect directly with patients, raise awareness of ongoing research and help with recruitment. Such organizations include the National Institute of Social Care and Health Research, European Huntington’s Disease Network, NIHRs National Cancer Research Network, Diabetes Research Network, Dementias Disease and Neurodegenerative Disease Research Network, Cambridge University and Warwick Medical School. “YourTreatmentChoices is a service for patients. Ethical review is not required” says the Health Research Authority.

Investigators may be a little anxious they will be swamped with enquiries from patients who wish to join clinical trials. However, patients who are interested in learning and understanding about possible clinical trial options are in the minority. Research shows most patients are unaware about clinical trials. The site usage data shows that patients are, however, familiar with searching for information and it is the early adopters who are embracing the new concept of direct access to a trial doctor.

Investigators can encourage patient interaction by explaining to potential participants what the trial is about, and who can join. Ninety-eight per cent of patients surveyed said a video of the trial doctor or nurse alongside the written information will help them understand and encourage them to reach out to the trial team for advice, so the site offers the facility for investigators to add educational videos for trials they are responsible for.

Patients using YourTreatmentChoices are preparing for the future. Those with stage IV lung cancer, tongue cancer and metastatic breast cancer say they are looking at what clinical trials are available should they need to consider a trial as a treatment option in the future. It’s not all about drug trials though. Patients are making enquiries about a diverse range of trials encompassing observational studies, blood samples or genetic testing, drug intervention as well as psychology workshops that can impact a patients ability to cope with their disease or condition.

YourTreatmentChoices is featured on the websites of Macmillan Cancer Support, National Institute of Social Care and Health Research (NISCHR), E-Cancerhub and Scoop.it Family Medicine, and has appeared in “Love it!” Magazine. Interest in the website has also been shown by patient support groups and charities, BBC, WHO, NIHR, Research Networks, and pharmaceutical companies.

Tomorrows Medicines believe interactive decision tools that enable patients to find the trials that are most relevant to their condition and personal situation will further help patients who want to take an active role in managing their own condition.

Claire Nolan, YourTreatmentChoices
Daresbury, Cheshire
https://yourtreatmentchoices.com/
book review

THE PATIENT PARADOX by Margaret McCartney

Paperback: 336 pages  
RRP: £9.95  
Publisher: Pinter & Martin Ltd; 1 edition (28 Feb 2012)  
ISBN-10: 1780660006  
(reviewed by John Garrow)

EVERYONE WHO IS interested in the UK National Health Service (NHS) should read this magnificent book. I was sent a copy to review. I have read it all, and I shall keep it as an important reference source. The author is a GP who has used a format that will satisfy all sorts of readers. For those of us who want to read the evidence for every statement there are proper bibliographic references—more than 500 of them. For the beginner in this field there is a glossary to explain, for example, Randomised Controlled Trials, or the difference between Absolute Risk and Relative Risk.

The reader is left with no doubt that the author is a GP who genuinely wants to do her best for the patient. Also she sees all too clearly that the health service is being forced into a situation that is a Paradox: the most complex and expensive testing and treatment is freely available for patients who are rich, but they are not ill, and investigation does them no good and probably does harm. However the ill patients who need the help that good doctors are able to offer cannot get it because the resources of the NHS are being wasted by activities that are no help to the patient, but enable the mandarins in Whitehall to monitor the obedience of the medical practitioners in recording pointless tests and treatments.

“I remember my father (who was not by nature given to rejoicing) being quite euphoric at the first experience of the new NHS.”

This year, 2012, is particularly important for the future of the NHS. The fundamental changes that are now being forced through parliament were never forecast by any political party. The practitioners upon whom the plans depend do not understand the plans and do not like them. Dr McCartney ends the book with a brief Epilogue: “Why I am not a pessimist”. She is optimistic because she trusts that as patients become better informed about what health workers can and should do they will demand evidence-based treatments, and reject the excessive non-evidence based claims for new drugs and procedures.

I do desperately hope she is correct. But where is the evidence that things will go that way? It happens that Dr McCartney qualified in 1994 so she has had 18 years of clinical experience.

Both my parents were doctors. I remember my father (who was not by nature given to rejoicing) being quite euphoric at the first experience of the new NHS. Everyone was entitled to free health care, not just those who were entitled to care paid for by their employers. In 1947 I went to medical school and witnessed the battle between the old consultants who were teaching us, and the influx of new ex-military staff who had experience of evidence-based medicine. One of these (later to become Professor of Medicine) was expert in electrocardiograms, which was a great novelty at the time. This caused nothing but scorn from the Senior Physician who always referred to him as “yon wee electrolocnic engineer”.

In 1952 I qualified, determined to carry the banner for evidence-based medicine, and retired at the age of 65 in 1994. So if we join my 42 years with Dr McCartney’s 18 years we have 60 continuous years of observation.

I would like to be able to say that evidence-based medicine has grown stronger, but it seems to me that anti-evidence medicine is even more strong. It is pathetic that the Department of Health is only now realising that patients need to be treated with care and respect, and that these qualities in a health carer are as important as skill in medical procedures. The requirements for clinical trials are now so complex that only the big pharmaceutical firms can afford to do trials, and the way in which the results of drug trials are reported are often designed to give too favourable a version of the value of the drug. Patient support groups are not unbiased—they promote access to treatments of the disease they favour, especially if the treatment involves a drug made by the pharmaceutical company that funds them. Legislation to punish false claims for medical drugs or devices are not being enforced, etc, etc.

I am not optimistic, but perhaps I am just too old. Please read this book, and pay attention to the message. As Dr McCartney writes, the future of an evidence-based NHS depends on YOU!

John Garrow  
Emeritus Professor of Human Nutrition  
University College London

FREE GUIDE TO DEBUNKING MYTHS

THE DEBUNKING HANDBOOK, a clever little guide to correcting misinformation, is now freely available to download. Although there is a great deal of psychological research on misinformation, this nine-page gem may be the first attempt to boil it all down into practical guidelines on the most effective ways to reduce the influence of myths.

The Debunking Handbook is written by cognitive scientist Stephan Lewandowsky, an Australian Professorial Fellow at the University of Western Australia, and John Cook, Climate Change Communication Fellow at the University of Queensland, who also created and runs Skeptical Science.


The text is enjoyably written and rich in examples, illustrations and suggestions for successful debunking tactics. It is intended as a guide for communicators in all areas who encounter misinformation, and will be welcomed by HealthWatch members. It explores the surprising fact that efforts to correct myths can sometimes reinforce the myth in peoples’ minds. Communicators need to be aware of the various backfire effects and how to avoid them.

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STANDING UP FOR SCIENCE

MEMBERS OF HealthWatch were invited by Diana and Malcolm Brahams to be their guests at the Medico-Legal Society’s meeting on Thursday 12th January, when Tracey Brown, the Director of Sense About Science, spoke on *Perils and Progress in making sense of evidence in public debate.*

Sense about Science (SAS) chases up “bad science” in the media found under headlines such as: “Can goats' blood serum help multiple sclerosis?” “Can crystals boost the Immune System?” and “Is wi-fi dangerous?” Cloning, genetically-modified foods and the claim that immunisation is linked to autism have also been contended by them.

Just as scientific journals use peer review before publishing new facts, SAS tries to equip the public to ask searching questions when they “don’t know what to believe.” Half a million copies of their free publication PEER REVIEW—I don’t know what to believe* have been disseminated so far via free download or in hard copy.

They aim to encourage the use of evidence in the formation of policy, not for policies to be launched first and then evidence found to back them. If issues are raised which are inconsistent with a policy, there is the temptation to drop the inconvenient piece of evidence. By way of illustration, the early-warn signs of the emerging BSE crisis were ignored until too late.

In the light of their experience with the Simon Singh and Peter Wilmshurst cases, SAS hopes to see a reform of the Libel law in the forthcoming Queen’s speech.

Pseudo-scientific newspaper or radio features often incense scientists. But instead of lamenting the issue with their colleagues at work, scientists should question reporters and broadcasters about the evidence for their comments and ideally put themselves forward to share their expertise voluntarily with others. When a homeopathic treatment purporting to offer a cheaper alternative to established anti-malarial treatment was launched, SAS harnessed available scientific opinion and persuaded the WHO not only to participate in the debate but also to firmly opine that the homeopathic claim was dangerous.

Newspapers tend to focus on a number of headline issues, which may include the latest scientific scandal. It is often the case that one newspaper is notable for failing to follow suit. Sense About Science has commended those journalists who manage to persuade their editor that, as it lacks scientific evidence, the story should be dropped.

Patients with chronic conditions for which there is no established cure are at the mercy of those offering false hopes of a “cure”, often at great expense. Instead of believing they have “nothing to lose by trying it”, patients need to question the evidence for such treatments before embarking on an expensive and futile quest.

Some celebrities now approach the organisation before giving their name to a diet, to avoid incrimination afterwards. So SAS is gaining a reputation.

More volunteers are needed to engage with the public and participate in peer review, rooting out the hypothetical and thrashing out the truth about scientific facts. One questioner suggested that judges could perhaps be taught how to assess the validity of the scientific evidence presented to them. Now there’s an idea.

Dr Jenny Isaacson,
Guild Commended Framer & Freelance Writer
Topmount Framing, Newbury

*Download at: http://www.senseaboutscience.org/resources.php/16-i-dont-know-what-to-believe*

The Medico-Legal Society runs an interesting and varied programme of not less than nine evening meetings a year. New members and their guests are welcomed. For more information see their website at www.medico-legal-society.org.uk

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The licensing of medical devices

not legally binding, Member States are expected to follow. In the UK, the MHRA is responsible for collecting and investigating Adverse Incident (AI) reports about specific devices via its Adverse Incident Centre (AIC) and, if necessary, issue a Medical Device Alert (MDA), warning users and healthcare professionals of potential safety concerns. In addition, the Directive requires device manufacturers to monitor the safety of their products and, where necessary, carry out corrective action, e.g., change design, replace the device, or modify instructions for use, and inform professionals and users by means of Field Safety Notices (FSNs) about any Field Safety Corrective Actions (FSCAs) they have taken. They are obliged to alert the MHRA and the Agency will determine whether the action(s) taken are sufficient to protect public safety, and monitor progress.

Much current debate centres on product safety and clinical effectiveness, with consumers, healthcare professionals, and politicians questioning the regulatory approval system and the level of vigilance applied, once devices are on the market.1,2 Demands for more rigorous pre-approval evaluations of new devices, including clinical trials, and systematic surveillance of newly introduced products (rather than reliance on only voluntary reporting of adverse incidents) may prompt the European Regulatory Authorities to review the Directive and modify as necessary, so as to protect the public and restore confidence in the device approval system.

Walli Bounds, Research Co-ordinator (retired)
Margaret Pyke Centre, University College London

References


All websites accessed 17 April 2012
last word

QUACKERY FOR CATS

BY THE TIME our cat Horace reached the age of 20 we were increasingly concerned about him losing his balance and took him to our local vet—the first time he had seen one since some dental treatment three years earlier, and his first time in north London.

We liked her. After examining him she said he had a heart murmur and felt arthritic. She advised against an x-ray as it would require a general anaesthetic, which was potentially fatal because of his age. She suggested glucosamine, which I said didn’t work in clinical trials in humans—something a vet might be forgiven for being unaware of. In any case, giving pills to a cat is a miserable job for both parties, especially the cat. We agreed on a wide range of blood tests since they could be done from a single sample, which would cause him minimal distress. These showed some liver and kidney failure. We agreed on palliative care only and bought him a hot water bottle for his bed.

Three months later Horace had a seizure, followed rapidly by several more. He was miserable. The time we had dreaded had come, but it was a Sunday and the vet was shut. I phoned round for an emergency vet and found one five miles away. I rang and was immediately put on hold. ‘Hold’ consisted of a lengthy recorded message on the advantages, for the caller’s pet, first of hydrotherapy and then of acupuncture. Now, I can see the advantage of hydrotherapy for dog owners who are too busy or lazy to take their pet to splash around in a pond, but it would be abusive to force it on a cat, the most water-averse of animals. And quackupuncture, to my mind, is an abuse of the trust that pets have in us.

‘Hold’ ended, by a curious coincidence, just as this message finished, and we were given an appointment for an hour or so later. I called a taxi and carried the feeble and depressed Horace in my arms. He was too unwell to struggle. He had two more seizures in the waiting room, one as I carried him in, and another in the vet’s arms.

I was astonished that the vet tried, in all seriousness, to sell me the idea of having the seizures investigated. I was firm that it was time for euthanasia, which is what he was then given. And he died straight away, peacefully and without any sign of distress. I wished I’d asked what the vet used—probably potassium chloride, as it seemed too fast a death for barbiturate.

As an afterthought, I wished that very old and very ill humans had the option of assisted dying, instead of having expensive and uncomfortable investigations to prolong a life that has already come to its logical end. Horace was 20 years, 8 months and 3 days old, and there is a now carved stone over his grave in the garden. He was the most affectionate and handsomest cat that ever lived, a non-pedigree blend of mainly Burmese and Siamese, dark brown with an even darker brown tabby overprint.

Caroline Richmond
Medical Journalist, London

GLOBAL HEALTH COMMISSION—IN WHOSE INTERESTS?

ALAIN BRAILLON, in a letter in The Lancet, expresses surprise that the creation of the independent academic Commission on Global Governance for Health organised by The Lancet, the University of Oslo, and the Harvard Global Health Institute, has been so publicly welcomed by the foreign affairs ministers of Brazil and France.

The new Commission is to use rigorous evidence-based analysis to offer a roadmap for the protection and promotion of health in the many global governance processes—including economic vested interests—that affect health. Yet Brazil, points out Braillon, is the third largest producer of tobacco in the world, while in France, the prevalence of daily smoking in 17-year-olds is rising, against the trend for high-income countries.

Dr Braillon was sacked from his post as a senior tenured consultant in Public Health in 2010, by the French Department of Health, against the advice of the National Statutory Committee, but continues to raise questions about the role of vested interests in healthcare.

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

HealthWatch welcomes membership enquiries from those who share its aims. Membership costs £30.00 per year, including hard copy newsletter sent by post (£40.00 for members outside Europe); or £25.00 for members anywhere in the world who agree to receive the newsletter only in pdf form by e-mail. Student membership, which includes the newsletter by e-mail only, is free.

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