“GAGGING” OF INDEPENDENT EXPERTS OVERTURNE D IN FRANCE

Two French public health experts are celebrating triumphs in the courts after devastating decisions were overturned recently. Both have fearlessly taken high profile and controversial stands on several public health issues, and look set to continue to do so.

Alain Braillon was a tenured senior consultant who had written or spoken publicly on several topics including prostate cancer screening and the power of the tobacco and alcohol lobbies. In December 2009 he was sacked from his post at Amiens University Hospital by a few members voting through an unscheduled agenda item at the hospital board. To his horror, the National Management Centre (France’s counterpart to the UK’s Department of Health) then supported the sacking, despite the fact that 70% of the health officials voted against his dismissal. Braillon was not given the opportunity to be present nor to defend himself at this appeal meeting. Regional programmes he had been conducting, including work helping smoking cessation for pregnant women, the prevention of perinatal transmission of hepatitis B virus infection and the management of suicide attempts were suddenly stopped.

For two years Braillon fought the decision. Finally, on May 10, 2012, the Paris Administrative Court cancelled the decision of the Ministry of Health which had fired him. The judgment notes that the abolition of his post had been illegal.

Dr Braillon is delighted that his name has been cleared, and is ready for his new life. However, he says, “My team and the programs I ran for the patients are all destroyed. As for my grants of more than €75,000, it is impossible to obtain information about where the money is now.”

Meanwhile his more senior colleague Gérard Dubois, a professor of public health at Amiens University Hospital and a past recipient of his country’s Legion d’Honneur for his work with anti-smoking legislation, has also enjoyed satisfaction. In an unrelated action, in November 2009 he was sued for libel by the French tobacconists’ union because he had stated on TV that cigarettes kill two smokers a year for every tobacconist. Denied support from his own university, he was supported in his fight by a non-governmental organisation, “Comité National Contre le Tabagisme”. The French tobacconists lost the case. When the tobacconists went before the Court of Appeal in November 2011 their claim for damages was rejected.

According to Braillon, the tobacco industry’s influence on Sarkozy’s government and French administration has been deadly, with tobacco sales levelling off between 2004 and 2011 and prevalence of daily smoking rising from 27.1% in 2005 to 29.1 in 2010. Such trends are an exception among developed countries, where sales and use of tobacco are falling steadily.

“There is a constant need to put pressure on governments to adopt or scale up appropriate policies. Tobacco control needs public health experts who are independent of commercial interests,” says Braillon.

Mandy Payne  

References
news

EXTENDING THE RESEARCH PROJECT

MOST OF YOU will be aware that the HealthWatch-sponsored study of the regulation of health claims* attracted considerable media attention. The study leader Les Rose has been heavily involved in discussions since the study was published, and we now have a much better understanding of how the law works—or rather doesn’t work. So now is the time for a follow-up study. We intend this to be much bigger, and with a more rigorous design. To achieve the former, we need more people to participate. The first study was very successful with only 12 people fully active. What could we achieve with 50 people? Yet that is less than half our current membership.

The next study is likely to target “alternative” therapies and diagnostic practices that can’t be deemed to be foods or food supplements, and with a more rigorous design. To achieve the former, we need more people to participate. The first study was very successful with only 12 people fully active. What could we achieve with 50 people? Yet that is less than half our current membership.

The aim is to constrain Trading Standards against diverting primary legislation. The Consumer Protection Regulations 2008, and the Enterprise Act. We should also try to avoid targeting traders who have “home authority” deals with Trading Standards, so that we get a better assessment of the consistency of enforcement across the UK. But this will be a participative project, and we are avidly interested in suggestions from the team that we intend to build. But of course, there is much more that we could do than this further study. HealthWatch could be a powerful force for better health outcomes, and the reform of the NHS presents an opportunity. Therefore we want to form a group of active members, who would like to do more than simply attend the AGM and read the newsletter. This is our invitation to you to join that group. If you care about the cause of evidence based health care, please email the secretary David Bender (david.bender@btinternet.com), and he will add you to the list. We very much look forward to working with you. The HealthWatch Committee

*abstract available at: http://mlj.rsmjournals.com/content/80/1/13.abstract

ASA’s “high volume” of homeopathy complaints

THE ADVERTISING Standards Authority have asked not to receive any more complaints about claims on homeopathy websites pending the results of their investigations currently under way. On their homepage “Hot Topics” section they announce, “The high volume of complaints and the number of marketers we need to work with means we’ve taken a different approach to our normal investigation process ... We’ve contacted marketers of homeopathic treatments and services about whom we’ve received a complaint and advised them to avoid making efficacy claims for treatments where robust evidence is not held to back them up. Specifically, we have told them to remove marketing claims that refer to, or imply, the efficacy of homeopathy for treating or helping specific health conditions.”

Mandy Payne


NEWS IN BRIEF

AFTER SERVING 19 years in the post of professor of complementary medicine at the Peninsula Medical School, Exeter, Edzard Ernst retired to become emeritus professor, on 12 June. Critics who expect him to fall silent will be disappointed, as he wrote in his blog recently, “I will continue to write and lecture; if anything, I will become more outspoken regarding the truth about certain issues.”

See: http://www.pulsetoday.co.uk/comment-blogs/14087591/i-m-retiring-so-critics-should-watch-out

A MEDICAL director of the Breakspear Medical Group, a private day clinic in Hemel Hempstead that claims to treat allergy and environmental illnesses, has been disciplined by a British Medical Council Fitness to Practice Panel. The panel concluded that Dr Jean Mono had administered inappropriate and potentially harmful chelation therapy unnecessarily after diagnosing lead toxicity using a urine test that has no demonstration. He is in such a dispute that chelation therapy unnecessarily after diagnosing lead toxicity using a urine test that has no demonstration. He will refer to, or imply, the efficacy of homeopathy for treating or helping specific health conditions.”

Mandy Payne


FRIENDS OF Science in Medicine continue to improve their new website and have produced a second newsletter with updates on media coverage and actions to promote evidence-based teaching in Australian universities.

http://www.scienceinmedicine.org.au/

A MEDICAL professor at the University of California-Davis was threatened with cuts in title and funding, and possible legal action, after he wrote an article criticizing a campus event promoting prostate cancer screening. In a 2010 co-written opinion piece in the San Francisco Chronicle, Michael Wilkes had explained research showing that PSA blood tests for prostate cancer may lead to unnecessary treatments that cause negative side effects, and suggested that doctors involved in the screening could have a conflict of interest. This June, the faculty’s governing panel called for medical school executives behind the threatening communications to apologize and to, “take concrete steps to prevent future violations of rights of academic freedom.”

Los Angeles Times June 14, 2012.

See: http://articles.latimes.com/2012/jun/14/local/la-me-ucdavis-20120614
DO WE KNOW WHAT WE MEAN BY EVIDENCE-BASED MEDICINE?

From an early stage EBM has been criticised for being too narrow or too rigid, for ignoring patient preferences, for downplaying “clinical judgement” or for encouraging the use of “cookbook medicine” in the form of intervention protocols. People have become aware of the criticisms and sought to counter them: in their 1996 article they say, “The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.” And also, “Without clinical expertise, practice risks becoming tyrannised by evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient. [On the other hand], without current best evidence, practice risks becoming rapidly out of date, to the detriment of patients.”

“...some critics assert that there is, ‘a lack of good evidence that teaching EBM improves the quality of medical education or the subsequent care of patients’: If this is true, it is a serious problem.”

To most of us all of this sounds like simple common sense; however, criticisms of EBM have not gone away and have, in turn, led supporters of EBM to try and broaden its appeal (some might say dull its cutting edge) by attempting to include in its definition a number of other features of what might properly be termed “best practice” or “conscientious practice”. Sackett et al begin this process of dilution when they refer to, “integrating individual clinical expertise (my italics) with the best available external evidence”. This confusion between evidence-based practice and best practice has also affected nursing: in 2009 Scott & McSherry defined evidence-based nursing as, “an ongoing process by which evidence, nursing theory and the practitioners’ clinical expertise are critically evaluated and considered, in conjunction with patient involvement (my italics again), to provide delivery of optimum nursing care for the individual.” There seems to be a logical trap here: tradition-based, anecdote-based or opinion-based practice, with which EBM is appropriately contrasted, may well involve the use of “clinical expertise” and “patient involvement”; these are features that are absent from EBM. Rather, it is the use of current best research evidence, and the fact that such use is explicit, which distinguishes the practice of EBM from other forms of healthcare practice.

Some critics go beyond merely saying that EBM is incomplete or too narrow and question whether it will improve the quality of medical education or the subsequent care of patients. I must say that I find this sort of approach both illogical and profoundly depressing: the whole history of western philosophy over the last four hundred years and of science in general is one of getting away from received authority, ancient tomes of wisdom and the teachings of “experts” in favour of going out and looking, by means of well planned studies and experiments, for the facts behind the problems that we face. To give a simple example, many doctors of my generation were brought up to believe strongly in the value of applying Eusol (essentially a form of dilute bleach) to wounds in order to keep them clean and promote healing. This policy was based on observations made in the Napoleonic War and other conflicts and was maintained for many decades until it was shown beyond doubt that Eusol inhibited fibroblast growth and activity and therefore actually prevented wound healing.

One further complication is that EBM is, in essence, a tool for arriving at an optimised clinical decision, almost always about what will provide the best biomedical outcome (survival, relief of symptoms, etc.), but the decision can be confirmed and implemented in several ways, for example, 1) the doctor tells the patient that treatment X should be carried out and makes it clear that he (the doctor) is not inclined to brook any argument; 2) the doctor and patient assess and discuss the decision together in terms of what matters most to each of them; 3) the doctor provides information to the patient but makes no further attempt to influence the decision. Thus an EBM approach may generate an excellent decision which is clumsily or badly implemented; this is not the fault of EBM, though it remains a focus of criticism.

As far as the development of EBM is concerned, the belief that it needed to be improved by including such things as, “patients’ opinions and priorities” and “clinical experience and expertise” in the definition has led to the development of newer “models” of EBM, often including the use of Venn-diagram type illustrations, for which no explanation or justification is given. Such, frankly, rather woolly-minded developments of the idea of EBM should be viewed with considerable scepticism and Charles and colleagues are to be commended for highlighting this issue.

Intriguingly, it is implicit in the idea of EBM (or so it seems to me) that the very process of implementing and teaching EBM-based practice should itself be subject to evaluation and, indeed, some critics assert that there is, “a lack of good evidence that teaching EBM improves the quality of medical education or the subsequent care of patients”. If this is true, it is a serious problem.

In summary, I don’t think that I can improve on Sackett and colleagues’ definition of evidence-based medicine and I would also commend their remarks about what EBM is not: it is not impossibly hard to practise, it is not “cookbook medicine” which ignores the needs and wishes of individual patients and it is not, or should not, be simply an excuse to cut costs. Nevertheless it is important for those of us who favour EBM to remember that it is only part of good clinical practice, that the development of best practice may involve the formal, critical appraisal of other aspects of clinical decision-making and, most important of all, that the promotion of both EBM-based practice and the teaching of EBM are areas which themselves require evaluation.

Roger Fisken
Retired consultant physician
North Yorkshire

See page 8 for references
THE EVIDENCE that eating five portions of fruit and vegetables a day protects against cancer and heart disease is very strong. In the greengrocery section of my local supermarket most packs of fruit and vegetables say how much of each constitutes one of your “five-a-day”. Most of the research on the beneficial effects of fruit and vegetable consumption has focussed on antioxidants because of the causative role of oxidative damage from free radicals in cancer and atherosclerosis. As a result, supplements of antioxidant nutrients such as vitamins C and E, β-carotene and selenium are widely available, commonly at much higher levels than reference intakes (RDA or DRV).

However, the results from randomised controlled trials (RCTs) of antioxidant supplements have generally been at best disappointing and in many cases have shown increased mortality among those taking the supposedly protective supplements. A recent commentary published in the Journal of the National Cancer Institute drew attention to the many RCTs of vitamin and mineral supplements that have shown either no protective effect against cancer or increased mortality. Indeed, very few antioxidant intervention trials have shown a beneficial effect, and most of those were conducted in populations with low intakes of antioxidant (and other) nutrients.

Supplements that could kill

One of the first “disappointing” intervention trials that I remember was the 1996 Cambridge Heart and Antioxidant Study (perhaps well abbreviated to CHAOS). I had been convinced by the epidemiology (e.g., from Professor Gey at the University of Berne) that relatively high plasma concentrations of vitamin E, above what could be achieved from a normal diet, were protective against atherosclerosis and heart disease. I started to take vitamin E supplements. Then the CHAOS study results were published. The good news was that vitamin E supplements led to a reduction in the number of non-fatal heart attacks (each of which causes irreversible damage to heart muscle), but the bad news was that there was a significant increase in fatal heart attacks among those taking vitamin E supplements. I stopped taking the supplements.

In 1994 the Nutrition Society was excited that one of the lead authors of the large trial of supplementation with vitamin E and β-carotene as protection against lung cancer had agreed to speak at a symposium held in Cork. This was a multi-million dollar study conducted in Finland involving 10,000 smokers, who were randomly allocated to receive vitamin E, β-carotene, both or a placebo. The presentation was excellent, but unfortunately for the speaker, all of us in the audience had already seen at least reports in the press, if not the full paper. There was increased death from lung cancer among those taking β-carotene supplements, as well as increased death from a number of other cancers.

A second study of β-carotene (this time together with preformed vitamin A, the CARET trial in USA) involved two groups of people at risk of lung cancer: smokers and those exposed industrially to asbestos dust. According to the trial design, 18,000 people were to be followed for 6 years, a design that would have sufficient power to detect a 23% decrease in the incidence of lung cancer. After three years the trial was halted; the paper in Journal of the National Cancer Institute was headlined, “Beta carotene fails to prevent cancer in two major studies: CARET intervention stopped”. You do not halt a major (multi-million dollar) intervention trial because there are not yet any significant positive results. Reading the paper we learn that the trial was stopped because there was a 46% excess mortality from lung cancer in the active treatment group. This is certainly a valid (and indeed ethically imperative) reason to halt the trial of a supposedly protective supplement.

I was invited to speak in a debate on antioxidants at the 2005 meeting of the Association of Clinical Biochemists, and had resigned myself to spending the whole of the Christmas 2004 vacation reading all the individual reports of intervention trials since the CHAOS study. To my immense relief (and moreso that of friends and family who did not relish spending time with a real “Grinch that spoiled Christmas”), the January 2005 issue of Annals of Internal Medicine was published in December, and included a meta-analysis of vitamin E intervention trials showing that most of them (and especially those involving relatively high doses of the vitamin) led to increased all-cause mortality. Two years later a meta-analysis of 47 low-bias antioxidant trials was published. This showed significantly increased mortality in trials involving β-carotene and vitamins A and E; vitamin C and selenium had no adverse effects in these trials. The Forest plot in the published paper showed that while 6 trials favoured the antioxidant supplements, 14 trials favoured the placebo (i.e., there were more deaths in the active treatment group). The remaining trials showed no significant difference between placebo and antioxidant. Although vitamin C was reported not to have adverse effects, there is at least one paper reporting doubling of cardiovascular mortality in post-menopausal diabetic women taking high dose supplements. This is because, at relatively high concentrations, vitamin C can react with proteins in the same way as does high blood glucose in poorly controlled diabetics, and so can increase the development of atherosclerosis.

The antioxidant paradox

There is obviously a problem here. A large body of epidemiological evidence, both cross-sectional and prospective studies, shows that people with high blood concentrations of vitamin E and β-carotene are significantly less at risk of atherosclerosis, cardiovascular disease and various cancers. There is also a plausible biological mechanism to explain why these antioxidant nutrients are protective. However, most of the intervention trials show increased mortality among those taking the supposedly protective supplements.

It may well be that blood levels of β-carotene and vitamin E simply reflect a diet rich in fruits and vegetables, and there are many other potentially protective compounds in plant foods, so that the real protective factor(s) may not be these two nutrients. Certainly we know that people with a relatively high intake of fruit and vegetables are less at risk of cancer and cardiovascular disease—hence the...
there is no need to provide evidence of either efficacy or safety.

three groups:

regulated. At present they are treated as foods, not as medicines, so

span of microsecond to nanoseconds, and are present in tissues at

normally unlikely to occur, since individual radicals have a life-

loses an electron, so it becomes chemically stable, but has created a

This is because the unpaired electron can be in one of several dif-

penetrated deeper into cells and cause damage in the nucleus, possibly

leading to cancer.

Do we need a change in the regulation of nutritional supplements?

The commentary that prompted me to write this makes a strong case for a change in the way in which nutritional supplements are regulated. At present they are treated as foods, not as medicines, so there is no need to provide evidence of either efficacy or safety.

A case can be made for regulating supplements by dividing them into three groups:

1) Those that provide up to about 2 – 3 times the reference intake (RDA or DRV). These should be readily available over-the-counter.

2) Those that provide up to 10 – 20 times the reference intake. These should only be sold by a registered pharmacist, who can ask what other supplements you are taking and advise you on potential hazards of overdose.

3) Those that provide more than about 20 times the reference intake. These should only be available on prescription. Part of medical training is in risk/benefit analysis, and your doctor should be able to evaluate the potential benefits and hazards of high dose supplements for you.

The Food and Drug Administration in USA, Food Standards Agency in UK and similar bodies elsewhere all provide guidance on high intakes of vitamins and other nutritional supplements, with prudent upper levels of intake where there is any evidence of hazard. Responsible supplement manufacturers follow these guidelines and recommend doses below the upper limits. However, many people who take supplements will have the view that if one tablet or capsule is good, two must be better and three even better. They may also be taking several different supplements, and so could be at risk of an excessive intake of a nutrient that is present in more than one formulation.

Finally, of course, there is the problem of irresponsible supplement manufacturers, who may have little or no quality control in their factories, and sell supplements of possibly dubious safety or efficacy on-line, from off-shore sites that cannot be regulated in any satisfactory way at present.

David A Bender
Emeritus Professor of Nutritional Biochemistry
University College London

References


3. Gey KF. Cardiovascular disease and vitamins. Concurrent correction of 'suboptimal' plasma antioxidant levels may, as important part of 'optimal' nutrition, help to prevent early stages of cardiovascular disease and cancer, respectively. Bibl Nutr Dieta 1995; 52: 75-91.


See also the HealthWatch position paper on multi-vitamin supplements, available at http://www.healthwatch-uk.org
COULD DENTAL X-RAYS CAUSE BRAIN TUMOURS?

DENTISTS MADE the news again in April with reports suggesting that dental x-rays could be a cause of meningioma—a type of tumour which grows in the outer membrane covering the brain. Researchers from Yale University, writing in the journal Cancer, had reported that in a person’s lifetime dental x-rays could double or triple the chances of developing such a tumour, and suggested that some screening (panoramic) X-rays if used on children may give a fivefold increase in risk.1

Since the Yale study was carried out, a new generation of modified CT scanners have been developed to image the face and jaws—these are Cone Beam Computerised Tomogram (CBCT). They are mostly found in major hospitals but also increasingly in some dental practices. Unlike the conventional radiograph which is a shadow image, CBCT lets you view the skull in three-dimensions. CBCTs are useful for assessing the condition and amount of bone prior to placing an implant, and very useful in unusual pathologies of the bone, e.g., cancer. In my own field I use them very occasionally when I need to know the precise position of unerupted teeth.

The radiation dose with CBCT is considerably higher than that of a small bitewing radiograph. Some states in North America will not allow the Cone Beam machines to be installed without permission from the state authorities.

A recent, unrelated, report in the Lancet2 which concluded that conventional CT scans of the skull cause an increase in brain cancer and leukaemia, further emphasizes the need to be cautious in the use of medical ionising radiation. To put the radiation dose in perspective a conventional CT skull scan is equal to more than 200 bitewing X-rays (see table, centre). In this study the medical records of 180,000 patients under the age of 10 were examined, so the baseline data is clearly more reliable than the Yale questionnaire. For 10,000 children CT-scanned under the age of 10 there will be one extra case of leukaemia and one extra case of brain cancer. Given that the decision to take a CT scan of a child is unusual and only undertaken when there are potentially serious clinical conditions, the authors of the report point out that the advantages outweigh the disadvantages.

Keith Isaacson
Orthodontic consultant, and chairman of HealthWatch

References

Radiation doses in microsieverts

| Bitewing X-ray (per exposure) | <8.3 |
| Full mouth x-ray | 35-38 |
| Panoramic X-ray | 9-26 |
| Cone beam CT (CBCT) | 68-599 |
| Conventional CT scan of skull | 2000 |
| Radiation from natural sources | 2400* |


*World average, per year (source: www.unscear.org)
THE GEEK MANIFESTO: WHY SCIENCE MATTERS

by Mark Henderson

Hardcover: 336 pages  RRP: £18.99  Publisher: Bantam Press (10 May 2012)

THIS CALL to scientific arms could have been sub-titled The HealthWatch Manifesto. It should be read by all scientists interested in communicating evidence based medicine to the wider world and by all undergraduates—because science is of fundamental importance to everyone. I make no apology for this trite statement because it needs saying time and time again. Henderson explains why, simply and succinctly. The surprising thing is that no-one has done so before in this way.

His book underlines the shortcomings of Ben Goldacre’s otherwise brilliant Bad Science which laments how hopeless many journalists are. This, I fear, was a public relations disaster for science. This might sound like heresy, but we need to build new bridges, not knock down the old ones without putting anything in their place.

The Geek Manifesto is a giant of a bridge. Henderson writes, for example, that adversarial approaches to bad science reporting are important weapons in the “geek arsenal”. But they shouldn’t be the first to be deployed, he advises. Start attacking a journalist in an abrasive fashion, he adds, and he is as likely to become defensive and deaf to criticism as he is to change.

Formerly Science Editor on The Times, Henderson underlines this point by recalling a dodgy piece he once wrote. He says: “That I recognized my error was largely down to an sensationalist misinterpretation, but he took a different tack. In a calm and friendly fashion, he told me that I’d made some mistakes in my copy, but that wasn’t altogether rare or surprising in such a difficult and technical field.”

Weidberg invited Henderson to Oxford to meet him and his colleagues. This was, Henderson explains, a textbook example of how to turn bad media reporting to your advantage.

A great strength of The Geek Manifesto is that it looks at science in the round. Take, for example, politics. Henderson reports that just one MP—Julian Huppert, Liberal Democrat member for Cambridge—worked as a research scientist before turning to politics. A scientific education and political career are often incompatible. Student politics, in which many aspiring leaders cut their teeth and begin networking, tends to be the preserve of those reading humanities and social sciences, partly because they have more time.

Crossing from the scientific to the political domain is difficult because of fundamental cultural differences. Henderson tells a story by Richard Dawkins about an elderly professor with a hypothesis that was disproved by a visiting researcher. The old man reportedly stood up, went to the rostrum and shook his hand and said, “My dear fellow. I wish to thank you. I have been wrong these 15 years.” The audience clapped their hands to the raw. This kind of U-turn reflects intellectual honesty, but Henderson believes that in Westminster and Washington, it is seen as, “the stuff of the gaffe”.

I could cite many examples explaining what makes this book so strong, but far better that you read it yourself and enlist in the geek army. Get more directly involved. Too few geeks, Henderson believes, join political parties.

Reviewed by John Illman

Medical author and journalist, London

BIOETHICS: ALL THAT MATTERS by Donna Dickenson

Paperback: 160 pages  RRP: £7.99  Publisher: Hodder Education (29 Jun 2012)

DONNA DICKENSON argues that the bioethics debate has been ambushed by the idea that religion is the biggest enemy of scientific progress and by puerile fantasies about “enhancement” technologies to extend human ability beyond natural capacity—for example through designer babies.

But it’s not Opus Dei, she points out, that controls over 70 per cent of US drug trials: it’s for-profit companies. One in five human genes is now the subject of a patent, mostly held by private firms. This can prevent researchers from getting access to genetic material and force patients to pay inflated prices for tests and treatments.

So far so good. Moreover Dickenson has form. She is emeritus professor of Medical Ethics and Humanities at the University of London and the author of 20 books, including the best selling Body Shopping: Converting Body Parts to Profit. In 2006 she became the first woman to win the international Spinoza Lens Award for her contribution to the public debate on ethics.

Bioethics: All That Matters is one of a series in which authors, both academics and “public intellectuals” (yes, this is what the publishers say), compress their specialist subject into just 25,000 words and present 100 ideas to take readers further forward. Dickenson selects 20 books, ten landmark court decisions, ten literary works, ten films, ten websites, ten think-tanks and activist organizations, ten key concepts, ten key thinkers and ten key individuals who have shaped the field, for better or worse.

All this adds up to an ideal introductory guide to topics such as stem cell technology, reproductive tourism, patent law and cognitive enhancement. There are chapters on the global egg trade, genes and sacrificial lambs and professional guinea pigs and should we do whatever science lets us do?

But what I really wanted to know is missing. Dickenson says that unless biomedical aims to serve the common good and not the bank accounts of the scientists, researchers, drug firms and other institutions involved, it will betray its original purpose of alleviating human suffering and improving living conditions.

The big unanswered question is, what should we do about it? I would have liked to hear how Dickenson would reconcile capitalism, which, like it or not, is the lubricant of the world economy, with the many conflicting concerns of bioethics. This is an issue that extends way beyond healthcare into international economics and how (through investments) our pensions, among other things, are funded.

Donna, over to you. We know about the problems; we want solutions.

Reviewed by John Illman

John Illman
CONFUSED OVER HYPNOSIS FOR HIGH BP? YOU SHOULD BE...

On their website*, hypnotherapists Andy Bryce and Maxine Henk-Bryce (“a certified hypotension practitioner”) claim that Essential Hypertension is a term which means that there is no clear medical cause, and that therefore, “doctors can only manage the symptoms, as they don’t have the time or resources to manage the underlying emotional and lifestyle factors. The consequences are a lifetime of medication, constant uncertainty and worry.”

Later on they refer to NICE guidance, which acknowledges the role of lifestyle factors in hypertension, in order to justify their focus on emotional issues. Confusing that.

The reality is that doctors are very aware that stress can increase blood pressure, but then so does smoking, obesity, lack of exercise, high salt in the diet and genetics amongst other things. NICE also is very clear that if addressing lifestyle factors does not bring down blood pressure, then medication is recommended in order to reduce the associated risks of stroke, renal failure and heart attacks.

Meditation is a last resort to reduce the risk of dire consequences, it is not because of doctors’ ignorance or lack of time or resources as claimed. Perhaps the consequences of following their advice of avoiding a lifetime of medication would not be so desirable. They do not hesitate to define high blood pressure, “specifically it’s a blood pressure reading that’s consistently in excess of 140/90 mm/Hg”. All anyone would need to make the diagnosis, then, would be a reliable method of recording blood pressure.

It is strange then that at the bottom of their home page they write this waiver, “we are not psychologists, psychotherapists, physicians or other licensed health care providers...” and the information they provide is, “not intended to diagnose, cure, treat or prevent any medical condition or psychological disorder.”

Ok, that’s cleared up any confusion.

James May
GP Principal, London

*Website: http://www.simplydivinerelationshipstraining.com/pages/hypertension-whatis-highbloodpressure-reduce/