



HealthWatch

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Newsletter 91 October 2013

“SCANT EVIDENCE” FOR COSTLY HEALTHCHECKS

HEALTH EXPERTS are increasingly calling for the NHS Health Check scheme to be scrapped. Doctors who have expressed reservations publicly include Claire Gerada, chair of the Royal College of GPs,¹ who says the government is promoting the programme “against good evidence”, and John Ashton, president of the Faculty of Public Health, who reportedly has “grave reservations” about health checks, saying, “We should be focusing on disadvantaged communities—not finding more worried well.”²

Figures released in September by Public Health England (PHE)³ show that in the first quarter of 2013-14 nearly 300,000 people took up invitations from their GP or local pharmacy to have an NHS health check—a series of tests and questions about lifestyle and family medical history which is offered to healthy people between the ages of 40 and 74 every five years. Cost to NHS: £24 per check. The programme aims to save the NHS £176 million in the next 15 years by spotting hidden disease linked to “silent risk factors” such as high blood pressure and cholesterol. But when HealthWatch asked PHE for evidence, the response was not convincing.^{4,5} “An economic model by anonymous authors not factoring in harm, is not evidence,” said Susan Bewley, Professor of Complex Obstetrics at Kings College London and HealthWatch committee member.

We drew PHE’s attention to a recent Cochrane review⁶ which found that general health checks are not associated with reductions in mortality or morbidity. Professor Kevin Fenton, PHE’s director of Health and Wellbeing, responded: “There is a huge burden of disease associated with conditions such as heart disease, stroke, diabetes and kidney disease and many of these long term conditions can be avoided through modifications in people’s behaviour and lifestyles.

“Although we recognise that the programme is not supported by direct randomised controlled trial evidence, there is nonetheless an urgent need to tackle the growing burden of disease which is associated with lifestyle behaviours and choices. All elements of the health checks follow well recognised and evidenced clinical pathways approved by NICE and the existing relevant evidence, together with operational experience accruing on the ground, is compelling support for the programme.” He also referred to an Expert Clinical and Scientific Advisory Panel to be established to review emerging evidence and research needs.

Susan Bewley called the PHE evidence “scant”. “The Healthcheck programme misuses science about patients with problems who are already attending medical services and misapplies it to the well in whom it cannot work in the same way.

“Professor Fenton has made it clear that he would not describe the NHS healthcheck as a form of screening, which I would take issue with. However, he does appear to admit that it is not based on any credible evidence of efficacy. The 2008 economic model⁵ by anonymous authors not factoring in harm, was not evidence, and nor will the refreshing of that economic model be the generation of new evidence. An evaluation of enforced implementation will naturally be biased by inequitable uptake, professional beliefs, politi-

cal pressure and vested interests.

“Scientists, taxpayers and journalists should be much more questioning. Who’s being paid to do these checks and why is something that is not proven to work being mandated by public health regulations? If people cannot be given information as to the benefit or risk of taking up the healthcheck, then they cannot be giving informed consent—so it is immoral as well as a waste of money. The fact that a problem is large and pressing is a pretty feeble justification for doing something expensive that doesn’t work, especially when that will divert money from the sick to prioritise the well. I’m a doctor who wouldn’t sleep easily at night with this on my conscience. If more evidence emerges that it doesn’t work, will he tell ministers to stop?”

Margaret McCartney, GP, author and HealthWatch’s newest patron, wrote in the *BMJ*:² “A 2013 study in *BMJ Open* found that a third of people at high risk of having or developing type 2 diabetes were not identified through the health check. A few months later, a paper published in *Preventive Medicine* found modest reductions in risk of cardiovascular disease in high risk patients attending health checks and an increase in statin prescribing from 14% to 60.6%.”

Trisha Greenhalgh, Professor of Primary Health Care at Barts and the London School of Medicine and Dentistry, doubtless spoke for many GP’s when she tweeted recently: “I’ll do a deal with Jeremy Hunt: drop the ‘NHS health checks’ and I’ll have more time to be accessible to my elderly patients.”

Mandy Payne

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WELCOME FIONA GODLEE TO AGM

FIONA GODLEE, editor in chief of the *British Medical Journal* since 2005, and the journal's first female editor, will this month accept the 21st HealthWatch Award and her presentation will be titled: "What's wrong with the published evidence and what can be done about it?". Under Fiona Godlee's courageous editorship the BMJ has taken a high profile stance in support of a range important issues, including the exposure of the discredited MMR research and, most recently, the need for transparency in clinical trial data.

As well as writing incisively on a broad range of issues, Dr Godlee led the development of *BMJ Clinical Evidence*, which evaluates the best available evidence on the benefits and harms of treatments and is now provided worldwide to over a million clinicians in 9 languages. She has served as president of the World Association of Medical Editors (WAME) and chair of the Committee on Publication Ethics (COPE).

Fiona Godlee will receive the award and address the audience at the HealthWatch Annual General Meeting on Thursday 24th

October at the Medical Society of London, Lettsom House, 11 Chandos St, London, Greater London W1G 9EB (nearest Underground Oxford Circus). It begins as usual with a reception at 6.30pm. The meeting is free and open to all. The evening will end with a buffet dinner with wine at 8.45pm, at a cost of £45. If you have not yet booked your place for the dinner, please e-mail kenneth.bodman@btinternet.com (preferably before 15 October) and post your cheque (payable to HealthWatch) to Kenneth Bodman, 8 Eagle Close, Amersham HP6 6TD.

MARGARET MCCARTNEY: OUR NEW PATRON

WE WERE DELIGHTED this summer when Glasgow GP and award-winning author Margaret McCartney kindly agreed to join the illustrious and growing list of HealthWatch patrons.

Margaret has been a friend of HealthWatch since she was a deserving winner of the 2008 Award for her promotion of evidence-based medicine in general practice through her columns in the *Financial Times* and the *British Medical Journal*. Since then she has continued to speak up for evidence, whether in articles for the *BMJ*, broadcasting on Radio 4's *Inside Health*, blogging for the *Guardian*, *New Statesman*, and the GP magazine *Pulse* among

many others.

Margaret McCartney started writing after being infuriated by a newspaper article which claimed the CT body screening was the way to stay well, and famously refuses invitations to attend screening tests in protest against the lack of informed choice given to the public. She is the author of the acclaimed book "The Patient Paradox: Why Sexed Up Medicine is Bad for Your Health" (published 28 February 2012 by Pinter & Martin Ltd).

Follow her writing on her blog, <http://margaretmccartney.com/>

HEALTHWATCH TEAM RESEARCH ACCEPTED FOR PUBLICATION

A NEW RESEARCH manuscript prepared by members of the HealthWatch team has been accepted for publication by the journal *FACT* (Focus on Alternative and Complementary Therapies). The paper will present the results of a survey of medical students and should help identify areas where teaching could be improved.

The web-based questionnaire was sent to students to determine the extent and context of teaching on evidence-based medicine (EBM), and complementary and alternative medicine (CAM) in UK

Medical Schools from the student perspective. The article will be accompanied by an editorial by HealthWatch's secretary, David Bender.

Both pieces are expected to appear in print within the coming months. The authors of the paper are student committee members Derek Ho and Kenneth Chan, and full members Susan Bewley and David Bender.

Mandy Payne

NEWS IN BRIEF

APPLICATIONS are once more being invited from researchers hoping to receive grants from the HealthWatch Research fund to promote evidence-based medicine. Funded by a donation of £50,000 from a private supporter, the HealthWatch Research Fund will back projects that further the charity's aims and objectives. Applications will be assessed by a subcommittee of HealthWatch trustees. Individual applications may be for sums of up to £10,000, although it is anticipated that most bids will be for smaller amounts. Full details and application forms at <http://www.healthwatch-uk.org/healthwatch-research/>

BOMBARDED WITH unsubstantiated claims for 'pioneering cancer treatments', new diets and unfounded stem cell cures, patients risk being exploited financially and serious harm to their health. Now Sense About Science have collaborated with medical charities to publish a guide that helps people weigh up claims about 'miracle cures' on the web and in advertising. "I've got nothing to lose by trying it" was launched in September to enthusiastic media reviews. Find out more, and download your copy, at: <http://www.senseaboutscience.org/pages/ive-got-nothing-to-lose.html#Coverage>

DE HOGWEYK: LIFESTYLE HOUSING FOR ELDERLY PEOPLE WITH DEMENTIA

A new approach to dementia care is attracting worldwide attention. De Hogeweyk is a unique development in the small Dutch town of Weesp, south-east of Amsterdam. Compared to those in traditional care homes, the 152 severely affected residents at De Hogeweyk are physically fitter, take less medication, and they seem to be happier—yet the cost of their care is similar to that in conventional facilities. Dementia has been described as “one of the most important issues we face as a population”.¹ In the UK, there are currently 670,000 people diagnosed with the condition, and this number is set to double over the next 30 years.² It already costs the NHS more than cancer and heart disease combined. We met Jannette Spiering, Director of De Hogeweyk, when she presented her work at the Royal Society of Medicine’s 7th Medical Innovations Summit this June³ and her team kindly accepted HealthWatch’s invitation to tell us why they believe their approach is proving so successful

TEN YEARS ago the care home at De Hogeweyk was a four-floor ‘block of concrete’. Now it is a neighbourhood where life and wellbeing are just as important as care and where the label of ‘institution’ no longer applies—this is an innovative, humane and affordable way of caring for people with dementia.

People who suffer from dementia lose their grip on life. This is accompanied by restlessness. According to the De Hogeweyk vision, admission into a nursing home must signify as little change as possible from what the residents were used to at home. This means small-scale houses that look like ‘home’. Life there must also be virtually identical to the resident’s previous life. This may concern ‘big’, important issues such as religion and culture but also the smaller things such as set-up, music, daily schedule and customs.

“Conversations about the current neighbourhood began about seven years ago,” explains Jannette Spiering. “The basic starting point was our vision of normal living for elderly dementia sufferers. We wanted to get away from the traditional ‘care home’ label. Small-scale was a must; the houses had to just be ordinary houses. We also wanted to retain all the facilities that we already had including a café, restaurant, supermarket and meeting rooms. Finally, there had to be diversity within the houses to suit the lifestyles and it was important to build bungalows in order to encourage the independence of the residents; they had to be able to step out the front door and be outside.”

The communal facilities at De Hogeweyk are open to anyone, not just residents and their families. “We want to be a neighbourhood that is as ordinary as possible”, says facility manager Eloy van Hal. “We want to attract other people in precisely because of the fact that our residents can no longer leave the neighbourhood.” The approach contrasts with that of the country’s health authorities. “The Dutch Ministry of Health, Welfare and Sport advocate small-scale projects in residential areas for up to 50 residents,” says Spiering. “They create ‘golden cages’ in ordinary neighbourhoods and that is very different to integration. You deprive the residents of the opportunity to do ordinary things and you cannot assume that the rest of the area will provide voluntary aid. Residents cannot go outdoors safely in a neighbourhood with cars driving through it or in an area where they may get lost. These people are incapable of living independently and that is exactly why they have been assessed as requiring nursing home care. So we say; come to us, instead of the other way around. All of the facilities were installed right at the entrance to De Hogeweyk and this lowers the threshold to using the facilities for the residents and, simultaneously, guarantees their privacy.”

However, it is not just integration that has been turned ‘upside down’ but also care and living. Eloy van Hal: “Most of the environments in which dementia sufferers end up living do not look at all like real homes. Residents are still treated as though they are ill. Our residents, of course, receive the treatment they need but the

emphasis lies on normal living. Just look at a hospital—visitors to hospitals don’t ask about the medicines but want to know whether the food is nice. These are the most important things in terms of day-to-day experience and these are our top priorities.”

“It took many staff quite a while to get used to the development and start of this vision of normal living”, says Jannette Spiering. “How you can provide care as ‘normally’ as possible? Nobody washes themselves with water from a metal bowl at home. And do beds really have to be made by half past eight? At home you might do your shopping and then go and have a coffee. The beds can wait. This requires a different mentality and requires more from our staff than would be expected in an ordinary nursing home. As soon as people work here, however, and are seized by the vision, they get right behind it.

“How do you provide care as ‘normally’ as possible? Nobody washes themselves from a metal bowl at home.”

“Connections outside must also fit in with ordinary living. Everything that can be done in an ordinary neighbourhood must also be possible here. For example, we opted for an outdoor area that was not covered as this fits in with our vision. This, however, led to certain discussions—the Client Council were concerned that the residents would not be adequately protected and asked what would happen if someone forgot to put their coat on. Our vision is the guiding principle at exactly this sort of moment. An elderly person suffering from dementia is not ill. We, as the organisation, have to support this so as soon as a member of staff sees a resident walking around without a coat on a cold or wet day the employee will go to the resident and bring them back inside to get their coat. And if there is an appointment at the hairdressers on a day when there has been 10 cm of snow, you simply change the appointment. We often have to explain why we hold on so strongly to the notion of normal.”

The management is over the moon about how De Hogeweyk has developed. Jannette Spiering: “The neighbourhood is put to even better use than expected. This is particularly clear from the enormous feeling of freedom experienced by residents and visitors. They are free to go and make use of whatever they like, whenever they like. For example; every year we have a couple of festival weeks for the residents in the summer. This year there were all sorts of activities on the square, including a performance by a brass band. Often over 80 residents attended this event and it was extremely

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WHEN RCTs DON'T WORK

THE WORLD Health Organisation (WHO) has a clear set of criteria for assessing the strength of evidence for an association of any factor such as diet or environment with chronic non-communicable diseases such as cancer and cardiovascular and metabolic disease:¹



- **Convincing evidence** Consistent epidemiological evidence linking exposure and disease, with little or no contrary evidence, including: prospective observational studies; randomised controlled intervention trials and a biologically plausible mechanism
- **Probable evidence** Fairly consistent epidemiological evidence linking exposure and disease, with some contrary evidence. Intervention trials may be too short, too small or have incomplete follow-up. There is a biologically plausible mechanism
- **Possible evidence** Evidence is mainly from case-control and cross-sectional studies, with insufficient data from controlled trials. There is supportive data from clinical and laboratory studies
- **Insufficient evidence** Based on a few suggestive studies, but insufficient to establish a link between exposure and disease, with limited or no evidence from randomised controlled trials. More research is required to support tentative associations

I assume that all members of HealthWatch will accept that the strongest evidence is when the epidemiological studies all point in the same direction, there is a biologically plausible mechanism, and randomised controlled trials support the epidemiology. However, there have been a number of large scale RCTs of vitamin and antioxidant supplements for protection against cancer and cardiovascular disease in which the results have been disappointing, or have even shown an adverse effect of the supplements. How can we account for these findings?

The theory was wrong?

It is possible that in some cases the hypothesis that a given nutrient is protective against a disease is incorrect. Thus, cross sectional and prospective studies showed clearly that low plasma carotene was associated with a higher incidence of various cancers, and an eminently plausible hypothesis was developed on the basis of oxidative radical damage leading to the development of cancer, and beta-carotene was shown to be an effective radical trapping antioxidant.² Two large intervention trials of beta-carotene in people at risk of lung cancer (smokers and those occupationally exposed to asbestos) showed that more people in the intervention group than the control group died from lung cancer.^{3,4} Indeed, the CARET trial⁴ was stopped early because of a 28% excess cases of lung cancer and 17% excess deaths in the intervention group.

One answer to this paradox might be that although the epidemiology showed that a high plasma concentration of beta-carotene was associated with a lower risk of developing cancer, plasma beta-carotene may simply be a marker for consumption of fruits and vegetables, which contain a wide range of potentially protective compounds, and that beta-carotene was not itself the protective compound. A diet rich in fruit and vegetables is also likely to be low in fat, and especially saturated fat.

Alternatively, it might help to read the original paper that described the antioxidant action of beta-carotene.² This stated that: “It exhibits good radical-trapping antioxidant behavior only at partial pressures of oxygen significantly less than 150 torr, the partial pressure of oxygen in normal air. Such low oxygen partial pressures are found in most tissues under physiological conditions. At higher oxygen pressures, beta-carotene loses its antioxidant activity and shows an autocatalytic, pro-oxidant, effect, particularly at relatively high concentrations.”

So, in this case, the plausible biological mechanism was in fact incorrect—or at least based on incorrect interpretation of the chemistry involved.

More is not better

Meta-analyses of intervention trials with vitamin E and other antioxidants show an excess of deaths from all causes in the intervention group in a majority of cases.^{5,6} It is possible that we are looking at a U-shaped curve—low antioxidant status may be a factor in cancer and cardiovascular disease, but at high concentrations the antioxidants may also act as radical-generating pro-oxidants. Antioxidants act by forming relatively stable free radicals that persist long enough to undergo reaction to non-radical products. However, this means that they also persist long enough to penetrate deeper into tissues and plasma lipoproteins, and so cause more damage, so above a certain level of intake the “protective antioxidants” actually become tissue damaging pro-oxidants.

The intervention started too late

Most, if not all, of the trials of folic acid and other vitamins to reduce plasma homocysteine, and hence reduce cardiovascular disease risk have shown no effect on atherosclerosis and coronary artery disease, although some have shown a reduced incidence of stroke.^{7,8} All of these trials were on people who already had stable cardiovascular disease, and it is probable that the intervention came too late in the natural history of heart disease. Ideally we should start the intervention before there is significant atherosclerosis, but this would mean a trial lasting some 40–50 years, since we would have to start the intervention in children and wait until middle age for cardiovascular disease to develop (or not, if the intervention is successful). Unfortunately, no-one is going to fund such a long-term trial. We may, of course, get information (in about 2050) as a result of the mandatory enrichment of flour with folate in USA, Canada and a number of other countries—but by then it will be too late for many of us.

In 1987 the government of Mauritius, concerned about the high rate of cardiovascular disease changed the formulation of cooking oil (a government-owned factory was the sole source) from one based largely on palm oil to one based on soya bean oil, and hence lower in saturated fat and richer in polyunsaturated. There was the predicted decrease in average serum cholesterol concentrations,⁹ but there not been any report of a decrease in atherosclerosis and coronary thrombosis to date, and Mauritius is still among the countries

with highest mortality from cardiovascular disease.^{10,11} Again we will presumably have to wait for young people who have been raised on the presumably more healthful oil to reach middle age before we see any decrease in cardiovascular mortality.

There was not a real control group

Even if trials of folic acid supplementation are conducted with proper control groups, in countries in which enrichment of flour is mandatory it is unlikely that we will see any effects, because the control group already have a considerably higher folic acid intake than in countries where there is no mandatory enrichment.

Only a sub-group respond to the intervention

Here there are two possible reasons (apart from the heterogeneity of disease):

1. One is that genetic polymorphisms are important, and only people with one genotype are responsive to the intervention.
2. The second reason was brought home to me at a joint meeting of the Nutrition Society and the American Society for Nutrition in June, when a number of papers reported intervention trials with vitamin D supplements. Overall there was not a significant response, but if people were stratified by their initial vitamin D status then those in the lowest quartile (even though apparently adequately provided with the vitamin to prevent deficiency) showed a significant improvement in various biomarkers of immune function and metabolism.

Purists may object to post facto analysis of the data, but it will allow us to set appropriate levels for (in this case) vitamin D status, and to identify people who may benefit from supplements.

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De Hogeweyk: lifestyle housing for elderly people with dementia

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congenial.” Eloy van Hal: “There was one activity—painting with Friends of Art from Weesp. Residents started painting, became very involved in their work and ended up doing things they hadn’t done for years. This environment also helps the visitors and family who come to visit. They do not have to sit stiffly in the rooms but can walk around the neighbourhood and pop out to the shops with a family member or go and sit by the pond. This is hugely beneficial when you consider that nursing home residents in the Netherlands go outside for an average of 96 seconds per day and 60% of them never receive visitors.”⁴⁹

And the cost? It is not much higher than most regular care homes in Britain: the fees of approximately €5,000 a month are paid by the Dutch public health insurance scheme, to which Dutch taxpayers contribute through their social security deductions. Some residents also pay a means-tested sum.

There is a lot of research going on worldwide which has a focus on trying to find a cure for Alzheimers disease. In the meanwhile as long as there is no cure, we will have to provide the best care possible. Drug treatment, for example, can be reduced when demented people live in surroundings which cause less anxiety.

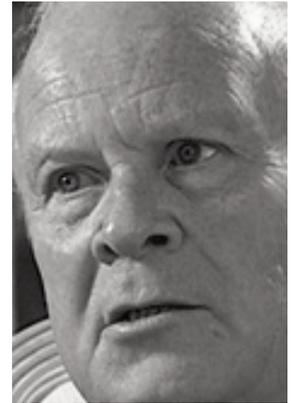
The De Hogeweyk team is very much dedicated to inspiring oth-

ers to re-think and reshape approaches to taking care of people with dementia, and they are active in supporting other teams in this work. If you are willing and really motivated to implement this new vision of care for the elderly it could be done in any other country or place. Of course there are many obstacles: financial, regulatory, and so on, but they can be overcome if you really have the drive to change care for demented people.

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TAMOXIFEN: SETTING THE RECORD STRAIGHT



THE BANNER headlines in *The Times* on Monday September the 9th screamed, “The lethal toll as women quit unbearable cancer drug tamoxifen” accompanied by a picture of a woman who was totally bald; it somewhat spoiled my day. I immediately tried to set the record straight in a letter to *The Times* that was not published, instead they published yet more anecdotal evidence of terrible side effects allegedly caused by tamoxifen from women on treatment for breast cancer. My fear is that this will only encourage more women to abandon the drug that has so far saved hundreds of thousands of lives all round the world since its introduction.

Not that it will help much now but I thought HealthWatch members might like to read here an extended version of the letter *The Times* saw fit not to publish.

In the mid-1970s, whilst working at the University Hospital of Wales, I set up a trial comparing combination chemotherapy with the newly available drug tamoxifen (Nolvadex ICI) for women with advanced breast cancer. One of the primary endpoints was quality of life (QOL) as measured by recently developed psychometric tests. Needless to say the women on tamoxifen showed more favourable outcomes for QOL with no significant difference in survival. Emboldened by that we launched the first study of tamoxifen as adjuvant therapy in early breast cancer in 1977, known as the Nolvadex Adjuvant Trial Organisation (NATO) trial.

On moving to the chair of surgery at Kings College London in 1979, I recruited professor Lesley Fallowfield, a research psychologist, to set up studies on the psychosocial consequences of the diagnosis and treatment of breast cancer amongst women not taking adjuvant systemic therapy. Her work demonstrated that whether the patient was treated with mastectomy or lumpectomy, about 30% went on to develop clinical depression. Prominent amongst the symptoms of depression were sleep disturbance and weight gain, and this was before adjuvant tamoxifen was included as standard of care. Furthermore the stress of the diagnosis and act of surgery precipitated the menopause amongst many women in their mid 40s and that of course is associated with hot flushes and thinning of the hair. In 1983 we published the first results of the NATO trial in the *Lancet*¹ and demonstrated that tamoxifen used after the treatment of early breast cancer could significantly improve survival even though we only used two years treatment with the drug (we now know that five years treatment produces a greater extension of survival). In 1985 Professor Jack Cuzick and I reported in the *Lancet*² that tamoxifen used as adjuvant therapy could significantly reduce the incidence of a new breast cancer in the contralateral breast. This observation, together with much laboratory and animal work, led

to the launch of the first tamoxifen prevention trial for well women at risk of breast cancer (IBIS I).

IBIS I recruited more than 7,000 women randomised to tamoxifen or placebo and its first report appeared in 2002.³ Although women on the active drug showed an increase in hot flushes and gynaecological symptoms there was no significant difference in weight gain. Furthermore although tamoxifen does lead to some thinning of the hair it's the chemotherapy that leads to total alopecia. Finally women on HRT for acute menopausal symptoms who are then diagnosed with breast cancer are encouraged to stop the HRT before they start tamoxifen. The rebound symptoms of the menopause on withdrawing HRT are then, not surprisingly, blamed on the drug.

Although I don't want to belittle the authentic side effects of the drug, because of the undoubted benefits of tamoxifen in improving survival after the treatment of breast cancer, it is essential for clinicians to learn how to recognise and manage the acute depressive illness and menopausal symptoms that are so common after the diagnosis of breast cancer. *The Times* for once has behaved irresponsibly in spite of its excellent track record in reporting on medical topics.

Michael Baum

Professor Emeritus of Surgery and visiting Professor of Medical Humanities at University College London (UCL)

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FOLLOW HEALTHWATCH ON TWITTER



NEWS FROM HEALTHWATCH is now reaching hundreds, and sometimes many thousands, of supporters of evidence-based-medicine each day.

Since the HealthWatch Twitter account was created this summer we have been “tweeting” topical 140-character nuggets on a daily basis. HealthWatch tweets disseminate our latest news, plus links to essential reading in the press and journals as soon as they appear. Our tweets are regularly “re-tweeted” by some of our more influential followers to their own contacts, sometimes reaching more than 10,000 like-minded people worldwide.

Examples of recent tweets: “Copper/magnetic bracelets no benefit in rheumatoid arthritis, says well-designed study. Who is sur-

prised? (PLoS)” “Mixing energy drinks and alcohol: research supported by industry may be downplaying harms (BMJ)” “See this brilliant initiative supported by Cochrane Centre to get students into evidence: students4bestevidence.net”

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Mandy Payne

INTEGRATED HEALTH AND POST MODERN MEDICINE: a further riposte

In the April issue of the HealthWatch Newsletter Les Rose responded to an editorial by HRH Prince Charles which appeared in the Journal of the Royal Society of Medicine. HealthWatch member Dr Richard Rawlins had, we later learnt, also written a reply to the Prince which he had sent for publication in the journal. As *JRSM* only published an abbreviated version, we agreed to air the full version here

PRINCE CHARLES' editorial is helpful in furthering our understanding of his advocacy, but more clarification is necessary if his wise words are not to result in the antipathy which greeted his speech to the BMA in 1982, and to which he makes reference. He tells us: "For many years I have advocated an integrated approach to medicine and health. By integrated medicine, I mean the kind of care that integrates the best of new technology and current knowledge with ancient wisdom. More specifically, perhaps, it is an approach to care of the patient which includes mind, body and spirit and which maximizes the potential of conventional, lifestyle and complementary approaches in the process of healing."

The Prince should be invited to clarify to which 'ancient wisdom' he refers. That the sun goes round the earth? That illness is due to imbalance of four humours? That kings have a divine right to rule? Having used Google, all I identified under this term was a commercial wholesale gift supplier, and a website for the Theosophical Society. This Society declares it provides "The Ancient Wisdom or Theosophy to give it its modern name." Given that its objects are: "to form a nucleus of the universal brotherhood of humanity; to encourage the study of comparative religion, philosophy and science; and to investigate unexplained laws of nature and the powers latent in man", perhaps this is indeed the Prince's base of reference. Theosophy is of ancient origin, and interested Paracelsus, who the Prince quotes. The modern Theosophical Society was founded in 1882 in New York by Helena Blavatsky. For some years its German secretary was Rudolf Steiner, until a schism and Steiner's foundation of Anthroposophy in 1912. Steiner was an Austrian mystic who claimed clairvoyant visions, believed in astrology, homeopathy, gnomes, and that children were the reincarnated souls of predecessors. Steiner also founded Biodynamics, the method of organic farming which emphasises the interrelationship between animals, plants and the soil, and which recommends planting in accordance with astrological indicators.

Prince Charles is reported to have experimented with biodynamics and to use the principles at Highgrove.^{2,3} Perhaps this is the wisdom of which the Prince speaks?

The Prince comments that in his speech to the BMA in 1982 he referred to Paracelsus's suggestion that the doctor "must be intimate with nature. He must have the intuition which is necessary to understand the patient, his body, his disease ... to be in sympathetic communication with the patient's spirits." Prince Charles recalled that when his speech drew attention to Paracelsus' belief that "the good doctor's therapeutic success largely depends on his ability to inspire the patient with confidence, and to mobilise his will to health," these ideas were regarded as "close to heresy."

Paracelsus was really physician Phillipus von Hohenheim (1493-1541), but adopted his professional name to suggest he was equal to or greater than Celsus (a streak of arrogant bombast which did not endear him to colleagues). He created astrological talismans to ward off illness and believed in the four Greek humours, adding mercury, salt and sulphur which embodied the soul. Certainly his views that health depended on the harmony of man and nature find endorsement today, but his hermetic and esoteric insights are now consigned to history. Medicine marched on and embraced the scientific methods of the Enlightenment. Medicine has no dogmatic orthodox belief, as what may be orthodox today will change with time—and evidence. The Prince can be reassured his ideas cannot be heretical, though they may be anachronistic.

There is no question clinicians should be caring and demonstrate

compassion. But that does not require progressive modern medicine to 'integrate' in any sense with alternative medical systems. 'Complementary approaches' are not needed to complete conventional treatments. The 'complementary approaches' spoken of by Prince Charles have included homeopathy, Reiki and a variety of systems to activate 'vital forces', none of which have been identified. They are alternatives to evidence-based modern medicine. The terms 'integrated', 'integrative', and 'complementary' are now becoming used more often as practitioners of those systems of medicine try to dissociate their metaphysical and arcane philosophies from critical analysis and avoid them being branded as the alternatives they are. The best of ancient wisdom is already incorporated into 'medicine.' To integrate medicine with systems for which there are no plausible evidence-base would do a disservice to patients—and to tax-payers expected to foot the bill. 'Integration' can indeed refer to an "approach to health which respects and includes the physical and social environment, education, agriculture and architecture." A manifesto Steiner would recognise, and most would support. But it is not helpful to conflate that meaning with the integration of pseudo-scientific and implausible CAMs, no matter how well meaning the intention.

I have no doubt patients feel better after a constructive therapeutic encounter with an empathic practitioner—due to type I effects of placebos. That should be termed 'condimentary medicine' to reflect that flavour is imparted, but with a lack of substance. There are no type II effects on any pathological or physiological process, no active molecules in homeopathic preparations, no sublaxations which can be adjusted, no energies imparted by holding hand positions over patients, no novel 'vital forces', no meridians stimulated by fine needles.

If evidence comes to light of any such things I hope the *JRSM* will publish the findings. But evidence will be expected to be robust, and withstand critical scrutiny as Lord Darzi has emphasised in his commentary on evidence-based medicine.⁴ That is the way forward for the RSM, and for medicine.

Yours sincerely,

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Dartmouth, Devon

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AN OVERHYPED HEALTH SCARE: GOVERNMENT SELL-OFF OF A BLOOD PRODUCTS COMPANY



IN THE MIDDLE of July I received, via the Medical Journalists' Association, a diatribe against the government's sell-off of a UK-owned plasma supplier to a US company, Bain Capital. I call the paper a diatribe as it was repetitive, and frequently repeated the case of HIV, which killed a huge number of haemophiliacs from contaminated factor 8, and vCJD, which has killed 176 people over 22.5 years.

I felt it overstated the case. The paper said that UK patients were being put at risk. Bain is owned by the Republican Mitt Romney. Plasma Resources UK employs a thousand people at DCI Biologicals in the US and 200 at the Bio Products Laboratory in Elstree, UK. DCI collects plasma and sends it to Elstree for separation into Factor 8, albumin and immunoglobulins for immune deficiency.

The story was the front page lead in the *Independent* on Thursday 18 July.¹ It stated: "The Government was tonight accused of gambling with the UK's blood supply by selling the state-owned NHS plasma supplier to a US private equity firm ... critics of the deal warned the Government that Bain Capital was the wrong company to own the NHS plasma supply line.

"Lord Owen, the former Health Minister, wrote to David Cameron earlier this year asking the Prime Minister to intervene and halt the sale. 'In 1975, against some resistance from those guarding the finances of the DHSS budget, I decided as Minister of Health to invest in self-sufficiency in the UK for blood and blood products,' he wrote. "I now believe this country is on the point of making exactly the same mistake again. The world plasma supply line has been in the past contaminated and I fear it will almost certainly continue to be contaminated.'"

The *Independent* continued, "After hearing of the sale Lord Owen told the *Independent*: 'It's hard to conceive of a worse outcome for a sale of this particularly sensitive national health asset than a private equity company with none of the safeguards in terms of governance of a publicly quoted company and being answerable to shareholders. Private equity has a useful function, as I saw in years past on the advisory board of Terra Firma, but Bain Capital should not have been chosen for this sale. Is there no limit to what

and how this coalition government will privatise?'"

The *Indy* added, "As the UK was unable to secure a long-term 'safe' blood supply for the NHS following the vCJD outbreak, the Government spent £50m in 2002 on the US firm that provided all of BPL's plasma. The majority of NHS hospital plasma supplies come from PRUK, which sources all its plasma from low contamination risk groups in the United States across DCI's network of 32 donor centres."

I was able to recognise that the statement—that the majority is NHS hospital supplies comes from PRUK—was untrue. This is because I am one of the patients who receives immunoglobulin transfusions. My hospital—the Royal Free in London—told me that they source their IgG from six different companies, all in the US. As they treat 700 of the UK's 3500 immune-deficient patients, and other treatment centres may also buy from a range of suppliers, this means that there is, in effect, not much of a story.

The Department of Health, though not always a reliable source of the whole truth, confirmed this. They told the BBC, "It is important to note that the NHS already currently buys 70% of plasma products from private companies based overseas, with 30% from PRUK."

Caroline Richmond
Medical Journalist
London

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