



# HealthWatch

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Newsletter 93 April 2014

## SCREENING CONCERNS TO THE FORE

**T**HE PROFILE of HealthWatch as an expert voice is being supported by our recent activities submitting responses to public inquiries. We submitted a detailed response to the Commons Select Committee consultation on National Health Screening,<sup>1</sup> which closed on 26 February, and have just responded to the Department of Health's Consultation on Legislation to Encourage Medical Innovation, which closes on 25 April.<sup>2</sup>

The National Health Screening inquiry was launched by MPs last December, to examine the scientific merits of national health screening programmes and to consider whether calls for health screening to be extended to cover conditions such as prostate cancer, lung cancer and post-natal depression are based on solid science.

**"... there has never been a greater imperative to concentrate funding on treating the ill, rather than screening the well using methods that have not been proven to offer overall benefit to the population."**

*HealthWatch, 26 February 2014*

HealthWatch's submission expressed concern about over-use of screening and the paucity of evidence and quality information on which patients can base informed decisions. It drew attention to the government's poor track record for placing evidence at the centre of its policy-making decisions. The submission particularly highlighted the issue of harms resulting from false positives and overdiagnosis in breast screening, and lack of evidence to support the NHS Health Check. It concluded:

"Far from offering unalloyed benefit, an overuse of screening results in overtreatment, the medicalisation of non-threatening conditions, physical harm and incalculable distress. At a time when there are significant financial constraints on the NHS there has never been a greater imperative to concentrate funding on treating the ill, rather than screening the well using methods that have not been proven to offer overall benefit to the population. HealthWatch urges you to apply an evidence-based policy to screening."

Also included was an annexe prepared by Les Rose which listed a number of serious unresolved and ethical concerns related to the The NHSBSP Age Extension Trial, whereby the roll-out of mammography screening to women in extended age ranges (47-50, and 70-73 years) is being carried out as a 10-year cluster randomised controlled trial by the Cancer Epidemiology Unit at the University of Oxford to test the hypothesis that screening is beneficial for these

age groups. A report about concerns over this screening extension trial is being prepared and will shortly be available on the HealthWatch website.

HealthWatch's response was drafted by chairman Keith Isaacson and reviewed by a team of committee members. Their efforts were greatly assisted by input from expert colleagues including two who have been particularly outspoken in their published views on screening: patron and 2008 HealthWatch Award winner Margaret McCartney; breast cancer surgeon and 2002 Award winner Michael Baum.

The 41 written submissions, including HealthWatch's, can be viewed in full on the consultation website (once on the page, scroll to the bottom and select "Written submissions" to view the list with links).<sup>1</sup> Other organisations whose submissions expressed concerns about the quality of the evidence base for the current NHS screening programmes or the quality of communications to the public included Sense About Science, Advocates for Honesty and Transparency in Breast Screening, Institute of Biomedical Science and Group B Strep Support; as well as a considerable number of lay or expert individuals.

The consultation on Legislation to Encourage Medical Intervention, launched on 22 November last year, relates to private members' bills sponsored by Michael Ellis, MP for Northampton North, and by Lord Saatchi, respectively. The bills identify the threat of litigation from clinical negligence claims as a barrier to medical innovation. The public and interested parties are invited to view the information and respond via the link below<sup>2</sup> by 25 April 2014.

*Mandy Payne*

*Editor, HealthWatch Newsletter*

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2. Department of Health (website). On: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/285272/9959-TSO-2901828-Legislation\\_to\\_Encourage\\_Medical\\_Innovation.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/285272/9959-TSO-2901828-Legislation_to_Encourage_Medical_Innovation.pdf)

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## CONSUMER PROTECTION REGULATIONS STUDY 2

**I**N JANUARY our chairman Keith Isaacson sent out a request via the Google group for volunteers to help with this study into the effectiveness of current consumer protection regulations (CPR), which is supported by the HealthWatch Research Fund. This will further the work of our first CPR study which resulted earlier this year in publication in the academic journal FACT.

In my proposal for the second study I committed to forming a management team, with myself supported by two assistants. Unfortunately I only received two offers of help, and only one was to assist with management. As the funding was contingent on compliance with the proposal, I am unable to progress without adequate human resources. I sent out another request to the Google group, and still received no offers to support me as project manager.

In addition to the management team, we require a large number of volunteers to submit complaints to Trading Standards and to fol-

low them up. I don't think we should expect committee members to shoulder the whole burden of meeting the aims of HealthWatch, and I know we have good people among our general membership. Please consider becoming involved. My time in HealthWatch has been enormously rewarding intellectually, and has also supported my professional life in terms of relevant knowledge. I very much look forward to working with many of you on this project.

*Les Rose*

*Freelance consultant clinical scientist*

## 2014 HealthWatch student prize now online

TWITTER has been buzzing with the news that entries are now welcome for the 2014 HealthWatch Student Prize. The competition tests students ability to critically evaluate clinical trial protocols, and the winners receive cash prizes of up to £500.

Student organizations have been circulating details of this year's competition via social media, and we would encourage

HealthWatch members to alert their contacts as well to ensure this year we get the highest possible number and quality of entries.

This year's prize is running thanks to generous sponsorship by Cambridge University Press. The closing date is June 30th. Protocols and entry form are at <http://www.healthwatch-uk.org/student-prize>.

### NEWS IN BRIEF

MEPs voted overwhelmingly on 2nd April in favour of a new law that will promote clinical trial transparency by requiring all drug clinical trials in Europe to be registered and their results reported in a publicly accessible EU database. The new law, which comes into effect in 2016, is a victory for the AllTrials campaign, but does not address the issue that we still don't have full reporting for all trials on the medicines we are already using. So if you haven't yet done so, please sign the petition on: [www.alltrials.net](http://www.alltrials.net)

AUSTRALIA'S top skeptic and long-time friend and supporter of HealthWatch has been awarded an Order of Australia Medal "for services to community health". Loretta Marron, three-time winner of Australian Skeptics' "Skeptic of the Year" is famous down under for her TV investigations of dangerous and discredited treatments. She is a founder member of "Friends of Science in Medicine". See: <http://www.skeptics.com.au/latest/news/loretta-marron-wins-order-of-australia/>

EXPERTS FROM HealthWatch have been busy on TV and radio. David Bender, HealthWatch's secretary and UCL's professor emeritus of nutritional biochemistry, was interviewed on Channel 4's "Food Unwrapped: Diet Special" programme on 6th January 2014 talking about "detox" foods and why they are not likely to offer the claimed health benefits. (Programme no longer available online). HealthWatch members Dr Margaret McCartney and Professor John Kirwan were on BBC radio 4's "Inside Health" talking about osteoarthritis.

Listen on: <http://www.bbc.co.uk/programmes/b03ts4g0>

REGISTRATION is open for the 2014 Preventing Overdiagnosis conference, hosted by the Centre for Evidence-Based Medicine, University of Oxford, September 15-17. Keynote speakers will include past HealthWatch Award winners Margaret McCartney and Fiona Godlee, along with Iona Heath, former president of the

Royal College of General Practitioners, London, England. Information: <http://www.preventingoverdiagnosis.net/>

CAN YOU use your expertise to give authoritative answers to questions on health issues such as sugar, misleading cancer cure claims, standards of health reporting, dementia tests, side effects? Sense About Science has teamed up with NHS Choices and Health Unlocked to launch a new online forum to help the public better understand the science behind health claims and to connect people with expertise. The more people that join and share insights into the science behind health headlines, the better the resource will become. Join the community here: <https://healthunlocked.com/healthyevidence>

EDZARD ERNST, now retired from the Peninsula University, where he was Europe's first professor of complementary medicine, continues to maintain a prolific output of articles on his blog, including expert critiques of the latest published research in the field of complementary and alternative medicine. In a recent entry, he considers whether the risks of manual therapies like chiropractic out-weigh the benefits. Follow his blog on <http://http://edzardernst.com>

SUSAN BEWLEY sent a link to a 2003 *BMJ* paper that remains important today and is well worth re-reading and disseminating. In "Simple tools for understanding risks: from innumeracy to insight", Gerd Gigerenzer and Adrian Edwards explain how simple explanations can help professionals and patients better understand risk to make more informed decisions and consultations more time efficient. HealthWatch wholly supports their call for instruction in efficient communication of statistical information to be made part of medical curricula and doctors' continuing education. See: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC200816/>

# Deadly Medicines and Organised Crime

By Peter Gøtzsche, reviewed by David Colquhoun

Published by Radcliffe Publishing Ltd on 1 August 2013. RRP £24.99 (320 pages, paperback)

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This review has been adapted for publication with the author's kind permission. Enjoy more of David Colquhoun's writing on his website: <http://www.dcscience.net/>

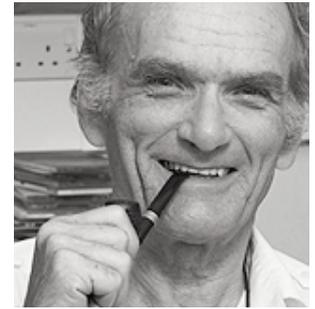
**A**S SOMEONE who has spent a lifetime teaching pharmacology, this book is a bitter pill to swallow. It makes Goldacre's *Bad Pharma* seem quite mild. In fairness, the bits of pharmacology that I've taught concern mostly drugs that do work quite well. Things like neuromuscular blocking agents, local anaesthetics, general anaesthetics, anticoagulants, cardiac glycosides and thyroid drugs all do pretty much what is says on the label.

Peter Gøtzsche is nothing if not an evidence man. He directs the Nordic Cochrane group, and he talks straight. His book is about drugs that don't work as advertised. There is no doubt whatsoever that the pharmaceutical industry has behaved very badly indeed in the last couple of decades. You don't have to take my word for it, nor Peter Gøtzsche's, nor Ben Goldacre's. They have told us about it themselves. Not voluntarily of course, but in internal emails that have been revealed during court proceedings, and from whistleblowers. Peter Rost was Vice President of the huge pharmaceutical company, Pfizer, until he was fired after he spoke out publicly against controversial and illegal practices in the industry. After this he was quoted in an interview with the magazine *Guernica* as saying:

"It is scary how many similarities there are between this industry and the mob. The mob makes obscene amounts of money, as does this industry. The side effects of organized crime are killings and deaths, and the side effects are the same in this industry. The mob bribes politicians and others, and so does the drug industry ..."<sup>1</sup>

The pharmaceutical industry has been called the biggest defrauder of the US federal government under the False Claims Act.<sup>2</sup> Roche led a cartel that, according to the US Justice Department's Antitrust Division, was the most pervasive and harmful criminal antitrust conspiracy ever uncovered.<sup>3</sup> Multibillion dollar fines have been levied on all of the big companies (almost all in the USA, other countries have been supine), though the company's profits are so huge they are regarded as marketing expenses.

It's estimated that adverse effects of drugs kill more people than anything but cancer and heart disease, roughly half as many as cigarettes. This horrifying statistic is announced at the beginning of the book, though you have to wait until Chapter 21 to find the data. I'd have liked to see a more critical discussion of the problems of causality in deciding why someone died, which are just as big as those in deciding why somebody recovered. Nevertheless, nobody seems to deny that the numbers who are killed by their treatments are alarmingly high.




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**"Their SSRI narrative goes like this. You don't expect to see improvements for many weeks ... You may get worse before you get better. And if the first sort of pill doesn't work, try another one. That's pretty much what a homeopath will tell you."**

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Gøtzsche's book deals with a wide range of drugs that don't do what they say on the label, but which have made fortunes because of corruption of the scientific process. These include non-steroidal anti-inflammatory drugs (NSAIDs), an area Gøtzsche describes as "a horror story filled with extravagant claims, bending of the rules, regulatory inaction ...". Other areas where he alleges major fraud include diabetes (Avandia), and the great Tamiflu scandal (it took

five years of pressure before Roche released the data—which show no good evidence to support claims that it reduces admissions to hospital or complications of influenza).<sup>4</sup> But the worst single area is psychiatry.

Two of the chapters in the book deal with psychiatry. Nobody has the slightest idea how the brain works (don't believe the neuroscience hype) or what causes depression or psychosis. Treatments are no more than guesses and none of them seems to work very well.

**T**HE PROBLEMS with the SSRI antidepressant, paroxetine (Seroxat in UK, Paxil in USA) were brought to public attention, not by a regulator, but by a BBC Panorama television programme.<sup>5</sup> The programme revealed that a PR executive working for GSK, had written in an e-mail:

"Originally we had planned to do extensive media relations surrounding this study until we actually viewed the results. Essentially the study did not really show it was effective in treating adolescent depression, which is not something we want to publicise."

This referred to the now-notorious study 329. It was intended to show that paroxetine should be recommended for adolescent depression. The paper that eventually appeared in 2001<sup>6</sup> grossly misrepresented the results. The conclusions stated "Paroxetine is generally well tolerated and effective for major depression in adolescents", despite the fact that GSK already knew this wasn't true. The first author of this paper was Martin Keller, chair of psychiatry and human behaviour at Brown University, RI, with 21 others.

But the paper wasn't written by them, but by ghost authors working for GSK. Keller admitted that he hadn't properly checked the results.<sup>7</sup>

That's not all. Gøtzsche comments thus:

"Keller is some character. The Massachusetts Department of Mental Health had paid Brown's psychiatry department, which Keller chaired, hundreds of thousands of dollars to fund research but nothing has been published. Keller himself received large sums from drug companies every year that he didn't disclose."

His department received \$50 million in research funding. Brown University has never admitted that there was a problem.

Another trial, study 377, also showed that paroxetine didn't work. GSK suppressed it.

"There are no plans to publish data from Study 377."<sup>8</sup>

Where were the regulatory agencies during all this? The MHRA did ban use of paroxetine in adolescents in 2003, but their full investigation didn't report until 2008.<sup>9</sup> It came to much the same conclusions as the TV programme six years earlier about the deceit. But despite that, no prosecution was brought. GSK got away with a deferential rap on the knuckles.<sup>10</sup>

Fiona Godlee (editor of the *BMJ*, which had turned down the paper) commented "We shouldn't have to rely on investigative journalists to ask the difficult questions."<sup>11</sup>

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# ARTIFICIAL PANCREAS AVAILABLE NOW ... apparently



**T**HERE IS a website<sup>1</sup> that appears to offer an artificial pancreas treatment for people with diabetes. This is the “holy grail” for diabetes researchers—a small device that will monitor blood glucose concentrations more or less constantly, and administer appropriate amounts of insulin (and perhaps also the counter-regulatory hormone glucagon) to maintain fine control over blood glucose. There is a good account of the state of development of the artificial pancreas on Wikipedia, together with a number of references and links.<sup>2</sup> It is not available yet.

By chance, while I was writing this piece I received by email a link to the 2013 American Diabetes Association website reporting progress towards an artificial pancreas. The video<sup>3</sup> (and transcript available at <sup>4</sup>) opens with “Each year, we are getting a little closer to creating an artificial pancreas”. It quotes Rich Bergenstal, of Saint Louis, saying “We can reduce hypoglycemia by close to 40%, particularly overnight ... So, I think this is a *first* step [my italics] along the process of developing the artificial pancreas.” It then goes on to describe recent studies: “So we’ve had insulin pumps for thirty years, we’ve had sensors for 5 to 7 years that measure blood sugars every five minutes and send the numbers to the pump... But for the first time now, we’re evaluating software in the pump that can read those sugars and automatically adjust the insulin. So we’re putting intelligence, we’re putting brains in the pump”. There is a quote from Eric Renard of Montpellier, one of the lead researchers involved: “There are two approaches. One option is to say: at the end of the day if patients report what they’re eating, glucose control shouldn’t be too bad. But there’s more to it than that: the patient has to calculate the amount of carbs and then report it. Or there’s complete automation, where the patient doesn’t have to report anything, the machine takes care of it. But as you can see *the results aren’t so good in this case* [my italics].”

On the [diabetes.net](http://diabetes.net) website,<sup>1</sup> we are told:

**The Artificial Pancreas Treatment provides the missing stimulation of the liver.**

**The liver provides the enzymes needed for the body to metabolize (burn) carbohydrates. This is the core problem that people with diabetes have, the inability to process this important type of food.**

**When these missing enzymes are restored, the body can process carbohydrates which provides each cell with needed levels of cellular energy (ATP) from carbohydrates.**

**With that needed energy the tissues heal themselves because the DNA remembers how to heal, naturally!**

There are two errors or misconceptions here:

- While the liver does indeed contain the enzymes to metabolise carbohydrates for energy production to meet its own needs, and for synthesis of fat and the storage carbohydrate glycogen, it does not provide those enzymes to other tissues. Muscle and adipose tissue cells take up glucose to metabolise it only in the presence of insulin, and insulin acts to stimulate the key enzymes of glucose utilisation in these tissues, as it does in the liver.*
- DNA does not “remember how to heal naturally”. If the DNA in a cell is damaged (e.g., by exposure to oxygen free radicals or ionising radiation) then there is indeed a mechanism for DNA repair in that cell. If the damage to DNA is too severely damaged for repair, then that cell undergoes programmed cell death (apoptosis). Damaged cells that do not undergo DNA repair or apoptosis are likely to develop into cancers.*

DNA can be said to have a memory, rather than being a memory, in one sense—so-called epigenetic modification. During normal embryological and early life development the process of cell differentiation and organ development is regulated by chemical modification of some bases in DNA—the process of methylation of CpG islands in DNA. These islands are control regions that determine whether or not specific genes are expressed in the cell, depending on the degree of methylation. As far as we know, once the DNA in a cell has undergone methylation, at subsequent cell divisions that pattern of methylation is maintained in progeny cells. It is well established that undernutrition *in utero* and in early life can lead to altered patterns of epigenetic modification, adaptation to low food availability, and a tendency to develop obesity and the metabolic syndrome leading to type 2 diabetes and cardiovascular disease in later life.

Insulin has two main groups of actions in the body:

- A series of rapid responses, within seconds or minutes, to increase or decrease the activity of existing enzymes that are involved in the metabolism of not only carbohydrates, but also fats and proteins. It also acts rapidly in muscle and adipose tissue cells to bring transport proteins to the cell surface, permitting these tissues to take up and use glucose as their major fuel, and form reserves of glycogen (in muscle) and fat (in adipose tissue). Because muscle makes up such a large percentage the body, the quantitative effect of insulin on glucose uptake by muscle is probably at least as important as its effect on the liver in terms of the control of blood glucose.*
- Slower responses (with a time-course of an hour or less) that involve increased synthesis of enzymes involved in glucose utilisation (and fat uptake from the bloodstream into adipose tissue), and decreased synthesis of enzymes involved in glucose synthesis (mainly in the liver and kidney) and mobilisation of fat reserves from adipose tissue.*

These actions of insulin are opposed by the hormone glucagon, which acts to stimulate the mobilisation of glycogen and fat reserves, and increase synthesis of glucose in liver and kidney. Although insulin is regarded as a ‘fed state’ hormone, and glucagon as a ‘fasting state’ hormone, normally both are secreted, insulin by the  $\beta$ -cells of the pancreas and glucagon by the  $\alpha$ -cells. It is the balance between the two hormones that permits fine regulation of the blood glucose concentration. The problem in type 1 diabetes (so-called juvenile-onset or insulin-dependent diabetes) is that there is essentially no production of insulin. This means that without injection of insulin, there is unopposed action of glucagon, increasing blood glucose and stimulating the release of fatty acids from adipose tissue, and synthesis of ketone bodies produced by the liver as additional metabolic fuels. In type 2 diabetes (so-called adult-onset or non-insulin-dependent diabetes) the problem is that tissues have reduced sensitivity to insulin, and the pancreas increases insulin secretion to overcome this insensitivity. Eventually the capacity of

the pancreas to secrete more insulin is insufficient to match the increasing insensitivity of tissues. People with type 2 diabetes are often treated with insulin, to maintain as close as possible control over blood glucose concentration. The problem is not that their tissues are completely insensitive to the hormone, but that they have reduced sensitivity—providing additional insulin is akin to turning up the volume of the TV set as your hearing gradually declines with increasing age.

The [diabetes.net](http://diabetes.net) website<sup>1</sup> tells us:

**For the last 20 years the Artificial Pancreas Treatment and Artificial Pancreas System have been in development ... It is now proven that APT will slow, stop and in many ways reverse the complications of diabetes, truly wonderful news to millions. And now it is affordable and available. ... The good news is that the DNA of every cell never forgets what it is supposed to do, and once proper metabolic energy is reestablished, the cell knows what to do and the body prepares [should this read repairs?] itself naturally and in its own special way.**

Unfortunately this last sentence is not correct. Insulin is required continually. If a diabetic who has maintained good glycaemic control by injection of a mixture of fast and slow acting insulin misses an injection, the result is a metabolic crisis of hyperglycaemia and keto-acidosis, as a result of unopposed glucagon action. If the cell does indeed “know what to do” and remember it, after metabolism has been normalised by insulin injection, then this would not happen.

We are told that:

**The FDA [US Food and Drug Administration] does not review the practice of medicine, only the devices**

This is correct; FDA regulates and approves (or not) medical devices and medicines (including licensing medicines for specific uses). The practice of medicine is not regulated by FDA. This is similar to the position in UK, whereby licensing of medicines and medical devices is regulated by the European Medicines Agency ([www.ema.europa.eu](http://www.ema.europa.eu)), while the practice of medicine is regulated by the General Medical Council ([www.gmc-uk.org](http://www.gmc-uk.org)). It is not clear why this statement appears on the website, but it is followed by:

**The Artificial Pancreas Treatment is a treatment using an FDA cleared infusion device as part of the system.**

The implication of these two sentences is that the artificial pancreas

treatment is approved by FDA, while it is not.

We are then told:

**The treatment effectively mimics the way a healthy pancreas excretes insulin in pulses. It results in normalized carbohydrate and lipid metabolism. It stops the complications of diabetes, and the tissues heal themselves. It needs only be used at most, 4 times a month to achieve these results.**

This last sentence is worrying. As discussed above, insulin is required all the time, not once a week. Also, insulin is secreted by the pancreas, not excreted. However, experience marking essays and exam papers over the years tells me that a number of borderline medical students also confuse secretion and excretion!

The website also states that they have carried out:

**... clinical trials at universities, individual clinics and national laboratories**

There are no references to published reports of these trials, and two requests via the website for references have not yielded any response.

So, so far we do not have an artificial pancreas; we have insulin pumps and glucose sensors, and semi-intelligent software. But the important point about all of this is that it requires glucose measurement every 5 minutes, and (artificial) intelligent continual adjustment of the insulin pump, not treatment only four times a month.

*David A Bender  
Emeritus Professor of Nutritional Biochemistry  
University College London*

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## Wikipedia challenged: “be fair to CAM”

**I**HAVE had a request on Facebook to sign a petition on the Change.org website writes Michael Henk. It reads “Jimmy Wales, Founder of Wikipedia: Create and enforce new policies that allow for true scientific discourse about holistic approaches to healing.” I have read some of the Wikipedia articles on various aspects of complementary and alternative medicine; I found them to be fair, science-based, and well-referenced, with references to publications by Edzard Ernst among others. So what is the problem?

The petition emanates from an American organisation called the Association for Comprehensive Energy Psychology (ACEP). This association claims to embrace approximately 1,300 licensed mental health professionals and allied health practitioners around the world. Its members are dedicated to “exploring, developing, researching and applying energy psychology methods to alleviate human suffering, enhance human performance and access human potential.” Energy psychology methods are specifically the Emotional Freedom Technique (EFT), Thought Field Therapy and Tapas Acupressure. They depend on the human subtle energy system, a concept similar, if not identical, to the ancient Chinese

‘qi’—the life force that flows through meridians in the body. EFT is the most widely practised. Its practitioners aim to treat anxiety, phobias, chronic pain and depression by instructing clients to focus on distressing thoughts or images while tapping points in the body corresponding to the ends of meridians; the tapping procedure is claimed to release energy blockages in meridians that cause negative emotions.

On their website the ACEP provide supporting evidence for the efficacy of EFT with testimonials and a few clinical trials. However, there is no reference to a controlled trial by the

*...continued on page 7*

## Deadly Medicines and Organised Crime

Book review continued from page 3

Despite all this, the current MHRA learning module on SSRIs contains little hint that SSRIs simply don't work for mild or moderate depression.<sup>12</sup> Neither does the current NICE guidance.<sup>13</sup> Some psychiatrists still think they do work, despite there being so many negative trials. Their narrative goes like this. You don't expect to see improvements for many weeks (despite the fact that serotonin uptake is stopped immediately). You may get worse before you get better. And if the first sort of pill doesn't work, try another one. That's pretty much identical with what a homeopath will tell you. The odds are that its meaning is, wait a while and you'll get better eventually, regardless of treatment.

It's common to be told that they must work because when you stop taking them, you get worse. But, perhaps more likely, when you stop taking them you get withdrawal symptoms, because the treatment itself caused a chemical imbalance. Gøtzsche makes a strong case that most psychiatric drugs do more harm than good, if taken for any length of time. Marcia Angell makes a similar case in *The Illusions of Psychiatry*.<sup>14</sup>

Gøtzsche will inevitably be accused of exaggerating. Chapter 14 ends thus:

"Merck stated only 6 months before it withdrew Vioxx that 'MSD is fully committed to the highest standards of scientific integrity, ethics, and protection of patient's wellbeing in our research. We have a tradition of partnership with leaders in the academic research community.' Great. Let's have some more of such ethical partnerships. They often kill our patients while everyone else prospers."

**B**UT THE EVIDENCE is there. The book has over 900 references. Much of the wrongdoing has been laid bare by legal actions. I grieve for the state of my subject. The wrongdoing by pharma is a disgrace. The corruption of universities and academics is even worse, because they are meant to be our defence against commercial corruption.

All one can do is to take consolation from the fact that academics, like Gøtzsche and Goldacre, and a host of bloggers, are the people who are revealing what's wrong. As a writer for the business magazine, *Fortune*, said:

"For better or worse, the drug industry is going to have to get used to Dr. Peter Rost—and others like him."<sup>15</sup>

At a recent meeting I said that it was tragic that medicine, the caring profession, was also the most corrupt (though I'm happy to admit that other jobs might be as bad if offered as much money).<sup>16</sup>

At present there is little transparency. There is no way that I can tell whether my doctor is taking money from pharma, data are still hidden from public scrutiny by regulatory agencies (which are stuffed with people who take pharma money) as well as by companies. Governments regard business as more important than patients.

One side effect of the horrific corruption is that it's used as a stick by the alternative medicine industry. That's silly of them, because their businesses include a good deal of misleading marketing. At least half of pharma products really do work.

Fines are useless. Nothing will change until a few CEOs, a few professors and a few vice-chancellors spend time in jail for corruption.

Read this book. Get angry. Do something.

David Colquhoun

Professor of Pharmacology, University College London

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Radcliffe Books, the publishers of "Deadly Medicines and Organised Crime", have offered HealthWatch supporters a 20% discount off their books, with expiry date 30th May 2014. Use the discount code **HWNL20** when ordering from their online shop: [www.radcliffehealth.com](http://www.radcliffehealth.com)

(please note - this offer from the publisher was made unconditionally and with no prior knowledge of the outcome of the review)

# E-CIGARETTES: FRIEND OR FOE?

*Peter Hajek, professor of clinical psychology and director of the Tobacco Dependence Research Unit, Wolfson Institute of Preventive Medicine and Barts and The London School of Medicine and Dentistry, Queen Mary University of London, writes:*

Dear Editor,

I wonder if the case of e-cigarettes is within HealthWatch scope? This is not about health professional bodies endorsing quack procedures, but about such bodies trying to block, because of ideology and vested interests, a development with a substantial potential for improving public health. An important element is disregarding evidence or engaging in its wilful misinterpretation.

Electronic cigarettes (EC) are a disruptive technology which poses serious threats to the tobacco industry, to sales of stop-smoking medications, and also to some established positions of tobacco control activism.

EC have a very good safety record so far. Health effects of their long-term use are not known, but there is no reason to expect that they could be more than a tiny fraction of the risks of smoking. There have also been no signs at all that EC are attractive to non-smokers. This is important, because the ‘gateway’ argument is increasingly dominating this debate. A recent report on EC use among US children was interpreted with alarm but in fact it is rather reassuring. Among middle and high school students in 2012, less than 1% of never-smokers had tried EC. In comparison, some 40% of the students had tried cigarettes. Daily use of EC in never-smokers was assessed in two studies, which found none. In contrast, of the substantial proportion of children who try cigarettes, about half become regular smokers. If my children were to try one of these two products, I know which one I would want it to be. Crucially, market analysts are reporting a decline in cigarette sales attributed to an increase in EC use.

And yet: The British Medical Association advises health professionals to tell patients that EC “are unregulated” when they are in fact regulated like any other consumer product, complying with a range of consumer protection regulations; and that their safety “cannot be assured”—presence of dangerous chemicals is listed without mentioning that the levels of these chemicals are well within limits considered safe in inhaled air at workplace (and of course only a tiny fraction of levels obtained from smoking).<sup>1</sup> Tellingly, BMA presents nicotine replacement therapy (NRT) rather than cigarettes as EC comparator and competitor. This is all from the latest BMA briefing which is less hostile to EC than previous BMA pronouncements,

but still states bizarrely that unless new regulation is imposed “e-cigarettes should not be considered as a smoking cessation aid or a lower risk option than continuing to smoke”.<sup>1</sup> It is difficult to see how a responsible health professional could claim this.

The BMA position is in fact enlightened compared to the WHO stance. WHO “strongly” (their own word) advise smokers not to use EC,<sup>2</sup> i.e., to stick with their tobacco cigarettes.

The European Parliament passed a series of strict regulations of EC with poor or no justifications which will limit the EC potential to benefit public health. For instance EC liquid can only have about 1/3 of the nicotine delivered by cigarettes, despite the fact that about 25% of users, likely to be the most dependent smokers who benefit most from EC, use stronger liquid than the allowed 20mg/ml. The officials of the Health Commission responsible for the proposal did not understand the literature and claim they are allowing nicotine levels equivalent to smoking. A large group of scientists involved in this research, some of which the Commission misquoted, wrote to the body who drafted the document pointing out this and other errors and their likely negative impact,<sup>3</sup> but this was ignored.

There is no logical justification for over-regulating EC and thereby protecting the market monopoly of conventional cigarettes; and to lobby for putting smokers off the switch which could potentially save their lives. I think this is a case worthy of our involvement. I am aware of the ‘gut reaction’ of mistrust most of us felt at the first encounter with e-cigarettes and with some of their more lurid adverts. ‘Gut’ is a useful guide where there is not enough information or time to think. In science however, brain is better.

Yours,  
PETER HAJEK

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## Wikipedia challenged: “be fair to CAM”

psychology department at University College of Okanagan, British Columbia,<sup>1</sup> which showed that the psychological benefits of EFT were obtained equally well by tapping on meridian points or on a doll. The ACEP claim that the Wikipedia pages are controlled by a few “self-appointed skeptics” who clothe their objections in the “narrowest possible understanding of science” (whatever that may mean!); they claim that these sceptics inhibit open discussion of innovation in health care, and that “fair-minded referees” should be given the responsibility of writing the pages on energy psychology.

In fact, the Wikipedia articles on EFT and the similar Tapas acupuncture technique are brief but fair and to the point. They refer to reviews by psychologists who have found that there is no evidence for the existence of meridians or of qi, and that there is no plausible mechanism to explain how tapping can add to effectiveness of psy-

chotherapy other than through the placebo effect. They conclude that any positive results of EFT can be attributed to standard cognitive and behavioural techniques that are included with the tapping, and that EFT is largely discredited by mainstream psychologists.

It would appear that members of the ACEP are concerned that information on the internet may deter potential clients. Wikipedia should be encouraged to ignore the petition and keep up the good work!

*Dr Michael Henk  
Consultant clinical oncologist (retired)*

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...continued from page 5

# WELL, DO YOU WANT TO SUCCEED?

“DO YOU WANT to succeed?” the dean of the medical school asked me. I had come to see him to talk about a job. I was moving out of London the way people with young families often do, my wife had a job fixed up and I, well, I was visiting local university bigwigs asking for work.

“Success? Do I want awards, accolades, gongs, praise, adoration, flattery, sycophancy even, invitations to give large plenaries at major American conferences, honorary degrees, invitations to join grand academies, opportunities to rub shoulders with ministers and influence policy, requests to write government reports so my name will be on every healthcare manager’s lips, the power to steer a medical school or university through difficult times, the respect of my peers, the pride of my family?

“Of course I want that—and more. I want my own three-minute slot on Radio Four in the mornings. Perhaps it could be called ‘Intelligent thought for the day’ in which I use my intelligence to talk intelligently on a topic of my choosing, near or far from my area of expertise, so the nation can benefit from my input. I want to be in every newspaper and on every television screen. I look forward to having my own smartphone app which indexes everything I have ever published or broadcast so people can find out what I think on a topic. Who needs Google, when what I think is available to millions? I want humanity to turn to me in its hour of need.

“Success, so defined, would be lovely, but there’s a catch: I think it is wrong to seek it. I hope I never do. Academic career success depends on the publication of striking findings in good journals. These increase the chance of getting large grants, which allow for advancement. There is no problem with this as long as it is the best work by the best people which gets into the best journals. Sadly, it isn’t. Good journals are more likely to publish positive and striking findings than negative or less striking ones, independent of their quality or importance. Therefore an academic who wants success must not attempt to publish an important but negative or less striking finding in favour of an unimportant striking or positive one. Evidence shows this problem is rife and may be getting worse.

“So what if some findings are more widely distributed than others? Surely ‘the truth will out’? Sadly not: the reason is ‘sampling variation’. Most scientific work involves taking a sample from a

population, measuring one or more things in that sample and then inferring things about the population from that sample. Because the sampling is random, the measurements of the sample may give a misleading impression of the population just by chance. This means that in a collection of studies examining the same issue, some will give one answer and some the opposite, just by chance. So, if some of the studies are less likely to be published than others because the results are less striking or are negative, then the body of the scientific literature may give a different, or even opposite, impression of the evidence on a particular question than would be shown if all the studies had been published. This undermines the whole scientific endeavour.

“Many jobs involve either selling people things they do not need, or facilitating this activity. Academic work is not like this. My work is the discovery and dissemination of highly applicable (though, so far, tiny) truths for the (very slight) betterment of humankind. I am part nerd and part superhero. I love it.

“Seeking success, as currently defined, means endangering the project and is therefore not worth it. Truly, if this is the price of success then I embrace complete, abject, unequivocal, undeniable, inescapable, failure. My career and its success is not important. I am not important. The work is important. The project is important. It is humanity’s best hope and I am proud to be a very small part of it.”

The above is what I would have said, but the dean is someone who has succeeded and I guessed from his question that he succeeded by seeking success, so I fudged it by saying I hoped my CV spoke for itself in that regard. I hope it did. Do I want to succeed? Well, I want to contribute. If my contribution is considered successful, then so be it. If not, then I’ll take it on the chin.

*William Lee*

*Reader in Psychiatric Epidemiology Plymouth University  
Peninsula Schools of Medicine & Dentistry (PUPSMD)*

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