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THE MEDICAL INNOVATION BILL: KILL OR CURE?



WITH A FLOURISH that might perhaps be forgiven from Britain's most famous advertising guru, Lord Saatchi has promised: "I intend to cure cancer." Seared by the death of his wife from primary peritoneal cancer he fulminated against the cruelty of the disease and then trained his anger at the abject failure of doctors and scientists to solve it. "Treatment for cancer is medieval, degrading and ineffective." The medical profession, he says, is frightened to try things out. And he's clear about what's to blame. "I'm going to show that scientific progress has been stopped by law."

Thus Maurice Saatchi launched a formidable PR campaign for his Medical Innovation Bill. He soon garnered more than 20,000 supporters and persuaded the Department of Health to lend its support. Saatchi is a man who has twice before piloted his ideas onto the statute book so he knows how to lobby. And who could deny his premise that if clinicians were free of legal constraint they wouldn't be so damnably conservative? His Bill would liberate surgeons and physicians to, "depart from accepted medical treatments" without risk of being sued for negligence if things go wrong. All they would need is consent from the patient and to show transparently that they have "taken full account" of the views of one or more appropriately qualified doctors.

A lot of very senior figures moved to endorse the idea, among them HealthWatch patron Sir Michael Rawlins, the former head of Nice and president of the Royal Society of Medicine and now chair of the Medicines and Healthcare Products Regulatory Agency. The distinguished Oxford oncologist, Prof Ahmed

Ashour Ahmed, celebrated a Bill that, "encourages a much needed attitude change." Lord Woolf, the former Master of the Rolls and Lord Chief Justice gave it his lawyer's seal of approval, acknowledging he is no expert in cancer but, "what I do know about, from sitting as a judge, are the cases where doctors are sued for negligence because they have innovated in the treatment they offer, rather than following generally-accepted medical standards."

I am appalled. Who am I to quarrel with such luminaries? I rarely if ever disagree with the great Mike Rawlins, but on this we find ourselves very much at odds. I regard this well-intentioned Bill as a recipe for quackery, dangerous for patients and with little potential for improving science, let alone as a cure for cancer.

It is true that the NHS haemorrhages well over £1 billion a year because of claims for negligence and I am quite prepared to accept that ambulance-chasing lawyers are a menace. It is also true that doctors tend to be conservative and that defensive medicine can be a curse. But the NHS Litigation Authority, which might have been expected to welcome the sweeping defence offered by the Bill, says none of the claims against it are relevant to innovation. The doctors' legal defenders, the MDU and the MPS, say the same. And poor Lord Woolf suffered a humiliating rebuke from the Solicitors' Journal after he admitted he couldn't document, or even recall, the cases he had cited which he conceded were from "very many years ago".

Anecdote is not a good reason for primary legislation, let alone a law that would sweep away patients' rights in the event of mishap. And make no mistake; the Medical Innovation Bill is sweeping, affecting not just cancer but every form of treatment with the sole exception of cosmetic surgery, and touching every age group including

children. There is no requirement for ethical overview. Any maverick doctor could experiment on the sick, every charlatan could prey on vulnerable patients, provided only that he or she had consulted a single colleague who might also be a maverick or charlatan. But quackery aside, even a fine and evidence-based clinician is likely to do more harm than good through uncoordinated experimentation on individual patients. I met Lord Saatchi early in the Bill's genesis and found him charming but seemingly unaware of the many medical tragedies caused by haphazard good intentions. And if, by some bizarre good luck, a magic bullet was discovered how would anyone be wiser? There is no requirement for data to

"There is no requirement for data to be formally collated or made public so if symptoms resolve, or the patient dies, we would never know if it was fortuitous, miraculous or murderous"

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New year's reading list

MMARGARET MCCARTNEY has followed up her acclaimed *The Patient Paradox* with a new book in which she has switched attention from screening to care of the dying.

In *Living with dying: finding care and compassion at the end of life* (Pinter & Martin, 2014) the Glasgow GP and HealthWatch patron takes a balanced look at the way we handle care of the elderly and terminally ill, and argues persuasively for a more compassionate and humane approach which puts the needs of the individual first. Bravely, she admits, "There have been many times when I've looked back over my own role in the death of a patient and been aware that I could have done better." Such open discussions about dying among the living are to be welcomed.

Some more recommendations from the committee:

The Emperor of all Maladies: a biography of cancer, by Siddhartha Mukherjee (Fourth Estate, 2011), multi-awardwinning and beautifully written story of mankind's attempts to conquer the disease in all its

manifestations, from earliest history to the present day.

Bad Medicine: doctors doing harm since Hippocrates, by David Wooton (OUP, 2007), described as a bold and challenging book, and the first general history of medicine to acknowledge the frequency with which doctors do harm.

For those without the time or inclination to read, we recommend the podcast series from this year's Reith Lectures by surgeon and writer Dr Atul Gawande. Entitled *The Future of Medicine*, they examine the nature of progress and failure in medicine. The four 45-minute lectures, originally broadcast 25th November to 16th December 2014, can be downloaded at <http://www.bbc.co.uk/podcasts/series/reith>.

Mandy Payne

NEWS IN BRIEF

PRESS INTEREST in the issues we've raised over the breast screening Age Extension trial continues. A substantial and hard-hitting feature in *New Scientist* has now highlighted HealthWatch's concerns, such as that Public Health England released the trial protocol only after three requests under the Freedom of Information act. The article quotes breast surgeon Michael Baum: "At a time when the whole question of screening is thrown into doubt, it seems utterly absurd to extend it," and HealthWatch committee member Susan Bewley describing the trial: "It's a juggernaut." (see Chairman's report, right, and *HealthWatch Newsletter* issue 95 for details of earlier coverage of this issue.)

New Scientist, 10 Nov 2014.

<http://www.newscientist.com/article/dn26529>

THE BOARD of NHS Lanarkshire will make no new referrals to Glasgow's Centre for Integrative Care (formerly the Glasgow Homeopathic Hospital) from 1 April 2015. The announcement in December came in response to the publication of a review by their Public Health and Health Policy team which concluded that, "whilst the subjective evidence from patients expressing benefit from and support for the service was strong, there was clear and unambiguous evidence that homeopathy and associated services were lacking in terms of therapeutic benefit. In addition there was a strength of clinical opinion across the UK that homeopathic treatments should not be provided by the NHS."

http://www.nhslanarkshire.org.uk/news/news/Pages/homeopathy_decision.aspx

PATIENT ADVOCATE Hazel Thornton applauded a recent *BMJ* Editor's choice article that criticized exaggeration in research press releases, but then despaired to find what she saw as exactly that in the very same issue of the journal. Thornton, honorary visiting fellow at the University of Leicester's department of health sciences, wrote in a rapid response to the 12th December issue, "We need look no further than a *BMJ* Research News headline on the same page of *bmj.com*: 'Tamoxifen reduces breast cancer rate in at risk healthy women by nearly a third, finds study' for a prime example of misleading news coverage resulting from a press release from a reputable University. It uses the familiar shock-tactic headline ploy covering a very newsworthy topic (breast cancer prevention) with a report that does not use natural frequencies to

'explain' the findings." She concludes, "Using 'numbers' (statistics) in this way to mislead and manipulate is unethical."

See: <http://www.bmj.com/content/349/bmj.g7603/rr/818827>

NEW WEBSITES launched by Sense About Science continue to push the case for evidence. *Evidence Matters: a campaign for accountable public policy* aims to put public pressure on policy-makers to use reliable evidence well by celebrating the good use of evidence, exposing its misuse, and sharing insights that help tell reliable evidence apart from opinion, advocacy and political ideology. *Ask for Evidence Online* is a new interactive website that makes it easy for anyone to question claims, and features examples such as, does sitting near a window in a restaurant mean you eat less; guidelines on Viagra prescriptions and MRSA-resistant pyjamas.

<http://evidencematters.org.uk/> and www.askforevidence.org

TWO YOUNG SCIENTISTS under fire are the joint winners of the 2014 John Maddox Prize for Standing up for Science. David Grimes, a post-doctoral researcher at the University of Oxford who works on modelling oxygen distribution in tumours, also writes bravely on challenging and controversial issues, including nuclear power and climate change. He has persevered despite hostility and threats, such as on his writing about the evidence in the debate on abortion in Ireland. The US writer Dr Emily Willingham, has brought discussion about evidence, from school shootings to home birth, to large audiences through her writing. She is facing a lawsuit for an article about the purported link between vaccines and autism.

<http://www.senseaboutscience.org/pages/maddox-prize-2014.html>

A FINANCIAL TIMES obituary celebrated the life of US dermatologist and philanthropist Ginter Kahn, who died recently aged 80. In the 1970's Kahn investigated the sprouting of tufts of hair on the bodies of participants in a trial of Upjohn's hypertension drug Minoxidil. He spotted the drug's potential for treating baldness, but he had to battle Upjohn in the courts for a decade to be recognised formally as one of its inventors. Now marketed by Johnson & Johnson as the hair loss treatment Regaine, it eventually made him a fortune.

<http://www.ft.com/cms/s/0/cc8601a4-497d-11e4-8d68-00144feab7de.html#ixzz3NUcOc4dn>

A LOUD AND CLEAR VOICE FOR CHANGE

THIS HAS BEEN a very active year with involvement in a number of issues. Before Christmas our attention was drawn to the House of Commons select committee's investigation into screening and the opportunity to submit our views. Extra meetings of the HealthWatch committee were convened and different aspects of screening were allocated to members. In collating the contributions, I referred to our patron Margaret McCartney's book 'The Patient Paradox'. As Mandy Payne had offered to help edit the 3000 word document, I asked for all contributions to be finalised a week before the submission date.



However on the day the submission was due in, a number of last minute improvements arrived by e-mail. I had a hectic morning running an outpatient clinic and at the same time making the alterations. The House of Commons computer was so inundated we had difficulty getting our document submitted, but with Mandy's help, it was accepted just before the cut off point of 12 noon.

Two of our members were invited to give oral evidence to the select committee and I attended the hearing at Portcullis house, next door to the Houses of Parliament, to hear Margaret McCartney and Professor Mike Baum make our views clear. After hearing their evidence, as far as I am concerned I will certainly not present myself for screening—for anything!

The Government's new organisation called Healthwatch England causes confusion with our own long-established charity and there were suggestions that we should change our name. Various options for a new name were put forward. To discuss the matter fully I hosted an "awayday" at my home. This was a very convivial event and the outcome was to continue to call our organisation: "HeathWatch" with a new strapline 'For Science and Integrity in Medicine'.

The Medical Innovation Bill (see Nick Ross' leading article, this issue) being promoted by Lord Saatchi is thought by many to be a quack's charter. However, not all agree, and our Patron Sir Mike Rawlins is one of those in favour of the Bill. We will be hosting a public debate where Sir Mike has agreed to debate the issue with Nick Ross, on Wednesday 4th March 2015, 7:00pm at King's College, Waterloo Road Campus. Details will be posted soon on our website.

We are very fortunate to have a research fund. Les Rose has done a lot of preparatory work on his project on Consumer Protection Legislation, he has obtained the necessary legal advice and is ready to launch it.

Two of our committee members, Susan Bewley and Les Rose,

drew our attention to the Age Extension Trial of Mammography Screening. It is very badly designed, does not meet the requirements of a trial and it is clear that whatever evidence results it is the government's intention regardless to extend the practice of breast screening to age groups in which its results are even less reliable than in those screened currently. We have taken this on board and have been successful in getting a number of articles and letters published in the *BMJ*, *The Times*, *New Scientist*, and *The Medico-Legal Journal* (see below for references).

Finally this is my third and last report and I must thank all the members of our committee, student and trainee members for their contributions. We had some very lively meetings which on occasions required Chairman's action!

I thank David Bender for his support as Secretary and Nick Ross for his input. We are heavily indebted and continually grateful to our barrister Caroline Addy who checks every issue of our newsletter for risk of attracting libel actions. However there is one person to whom we all owe a great deal—and I invite you to show your appreciation of—Mandy Payne, our editor.

Keith Isaacson

Outgoing chairman of HealthWatch committee

Further reading

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Wilson C. Critics say wider breast screening trial 'unethical'. *New Scientist*, 10 November 2014. See: <http://www.newscientist.com/article/dn26529>

Bewley S. Legal scrutiny of the age extension breast screening trial is required. *Medico-Legal Journal* 2014;**82**(4):167-8.

Nick toasts our top students

HEALTHWATCH PRESIDENT Nick Ross (2nd from right) enjoys a relaxed discussion over a glass of wine with our latest Student prizewinners, after he presented their awards at the Medical Society of London, 30 October 2014. They are, from left to right: Yuhan Ong from Aberdeen Medical School, our first-prize winner in the medical student category; with runner-up medics Arthur Woo of Glasgow University; Alicia Barnes of Keele University; Keith Sacco of the University of Malta; and Jenifa Jeyakumar of Kings College London. To the right of

Nick Ross is physiotherapist Lynette Fox of Nottingham University, who took first prize in the category of professions allied to medicine.

Unable to attend were runner-up medic David Isaacs of Brighton & Sussex University and runners-up for allied professions: Adam Peel from the University of East Anglia, and Ina Petrova Mastalurova from Aberdeen. Our admiration and hearty congratulations to them all!



FIGHTING FOR TRUTH IN SCIENCE

The 22nd HealthWatch Award was to the science writer Simon Singh. At the 2014 HealthWatch annual general meeting at the Medical Society of London, Nick Ross presented him with an ice bucket engraved on the lid with the words: "Simon Singh: fighting for truth in science". He gave a very enjoyable presentation, and an abridged version can be enjoyed again here.

MY TOPIC is my libel trial and some of the battles I've had with alternative medicine, alongside my colleague and friend Edzard Ernst. But to start with, I should stress that my background is not in medicine, but in particle physics. And, for most of my career in journalism, I focussed on promoting good science—exciting, interesting, challenging science—the kind of science we used to dream about when we were kids.

For example, a few years ago I heard a song on the radio by Katie Melua, called nine million bicycles, which contained the following verse:

*"We are 12 billion light years from the edge,
That's a guess,
No one can ever say it's true,
But I know that I will always be with you"*

It made me a little bit annoyed, because the song implies the universe is 12 billion years old, and it's not. Then she says, "That's a guess," but it's not a guess—this is science and scientists don't make guesses, we make careful measurements. Next she says, "no-one can ever say it's true". But that's not right because in science we always try to get closer to the truth. And finally, "I know that I will always be with you". Well at this point I felt I couldn't trust a word this woman says. So I wrote an article about this for the Guardian, and at the end I re-wrote the lyrics to make them a bit more accurate.

*"We are 13.7 billion light years from the edge of the
observable universe,
That's a good estimate with well defined error bars,
Scientists say it's true, but acknowledge that it may be
refined,
And with the available information, I predict that I will
always be with you"*

The great thing was that Katie Melua actually read the article, she got the joke, and we met up and she re-recorded the song, using my lyrics. Even better, the article about my re-write hit a big mainstream audience, so I was able to convey a bit of cosmology to the general public.

However, about ten years ago, instead of finding ways to communicate mainstream science, I began writing about pseudoscience. I started to get interested in some different kinds of claims that were being made in the name of science, that weren't very scientific, but which could have serious consequences. For example, I wrote about homeopaths who offered homeopathy pills as protection from malaria. Moreover, I worked on an undercover investigation with Sense About Science and we exposed the dangers of the advice that we found some homeopaths were giving to people travelling to malaria-affected countries.

Back in those days I still didn't know that much about alternative medicine generally, so I was interested to see a BBC 2 show in 2006 called "Alternative Medicine – The evidence". It was particularly memorable, because the narrator explained an astonishing clip: "In China this woman is having open heart surgery. But it is unlike any-



thing you will see in the West—she's still conscious. Because, instead of a general anaesthetic, this 21st Century surgical team are using a 2000-year-old method of controlling pain. Acupuncture."

I thought, either that's the most staggering bit of film I've seen all year, or there's something wrong here. I did a bit of digging and I learned that the Royal College of Anaesthetists had written a report for the BBC about that very piece of footage, and it confirmed that the patient indeed didn't have a general anaesthetic, but she had in fact received sufficiently large doses of sedative and painkilling drugs to make the acupuncture's role no more than cosmetic.

It was around this time I met Edzard Ernst, Professor of Complementary Medicine at Exeter University. We soon realised that we had overlapping interests, namely an appreciation of the importance of evidence and the desire to communicate research to the general public. In time, we wrote a book together¹ to look at the evidence for alternative medicine, to consider what does and doesn't work, and whether any of it could actually be dangerous. We had chapters about homeopathy, acupuncture and all kinds of other practices, and also we wrote articles in the press, to help people weigh up the risks and benefits of these treatments.

One of the articles I wrote at the time was on the subject of chiropractic and was published in the *Guardian* in April of 2008.² I mentioned the way that many chiropractors go from claiming to treat back problems to being able to treat things like ear infections and asthma, based on this rather odd philosophy that manipulating the spine is able to influence the rest of the body via the nervous system. As a result of writing this article I became the subject of a libel action brought by the British Chiropractic Association (BCA).

The case went on for two years, and I was facing costs of £500,000 were I to lose. Fortunately, the BCA finally backed down,

withdrew its lawsuit, and the case ended. It was a miserable time, causing a huge amount of stress and forcing me to dedicate half of my working time on the legal battle. Nevertheless, some good things came out of this. Firstly, it encouraged discussion and the challenge of chiropractic claims. Fiona Godlee, in the *British Medical Journal*, published a debate between Edzard Ernst and the BCA. She concluded³: “Readers can decide for themselves whether or not they are convinced. Edzard Ernst is not. His demolition of the 18 references is, to my mind, complete.”

Suddenly doctors were becoming more aware of what chiropractors were claiming. There were also campaigns run by people who are not really part of the medical establishment. For example, Simon Perry, Chris French, and Alan and Maria Henness of the Nightingale Collaboration, submitted 600 legitimate complaints about chiropractors to the General Chiropractic Council. Almost overnight, chiropractors reacted and began taking down their websites and withdrawing leaflets in order to avoid prosecution for claims that could not be supported by evidence.

“In Northern Ireland there remains a problem because Belfast’s libel laws have not yet been brought into line with the new Defamation Act”

It was around this time that the campaign to reform the English libel law started. There was a general sense that it was too easy to bring a libel case, and that this state of affairs was actually discouraging critical media reporting on matters of serious public interest. The burden of proof was on the writer, there was no public interest defence, and it was possible for companies to sue individuals and land them with high costs, with no risk to the organisation bringing the case.

What is more, a lot of these features were peculiar to English libel law, so if someone anywhere in the world wanted to issue a writ, they would be tempted to issue it here in London. This is what is known as libel tourism. Even the United Nations had condemned the English judges’ practice of welcoming rich libel tourists from across the world to their hospitable courts; and following a case in which an English judge ordered the censorship of a New York author’s book on terrorism, which had not even been published in Britain, the US Congress began drafting a law which would guarantee that English libel judgments have no validity in America.

My case was not unique. At the time, some of the other people

being sued for libel or being threatened included Ben Goldacre, Peter Wilmshurst, David Colquhoun, Andy Lewis, Mumsnet. Even the prestigious journal *Nature* was sued over an article on cosmology, and that case also lasted for two years and ran up huge costs. What is more, there were many good articles which were never even written because of self-censorship fuelled by a fear of a libel suit—what we call the “chilling effect”.

The Libel Reform Campaign was founded by Sense About Science, English PEN and Index on Censorship, with support from groups ranging from HealthWatch to Skeptics in the Pub, from academic journals to Mumsnet, and there were people all around the world who joined in, because they realised they could also get dragged into London’s Royal Courts of Justice. The Libel Reform campaign at www.libelreform.org received the backing of the editors of the *BMJ*, *Nature* and *New Scientist*, and people like Richard Dawkins, Ricky Gervais, Stephen Fry, Penn & Teller, James Randi, Sir Tim Hunt, Sir David King, the UCL Provost and 50,000 others.

After a remarkable grass roots campaign, the Defamation Act received royal assent on 25 April 2013, and became law in England and Wales at start of 2014. This change to the law of defamation aims to strike a fair balance between the right to freedom of expression and the right to reputation. Plaintiffs now have to show that they suffer serious harm before a court will accept the case. There’s protection for website operators, a defence of ‘responsible publication on matters of public interest’ and new statutory defences of truth and honest opinion.

But there is still work to be done. In Northern Ireland there remains a problem because Belfast’s libel laws have not yet been brought into line with the new Act. So the campaign is still ongoing, and with the backing of HealthWatch and all our other supporters, I am optimistic that Northern Ireland will realise that necessity of bringing its defamation laws into the twenty first century.

Simon Singh

Author; journalist and broadcaster, London

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2. Singh S. Beware the spinal trap. *Guardian*, 19 April 2008.
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The Medical Innovation Bill: kill or cure?

be formally collated or made public so if symptoms resolve, or the patient dies, we would never know if it was fortuitous, miraculous or murderous.

The Saatchi machine (<http://medicalinnovationbill.co.uk/>) ignores this, and fails to report the fact that the vast majority of medical professional bodies and charities have severe reservations (<http://www.stopthesaatchibill.co.uk/>). Senior lawyers too have on reflection turned against the Bill, citing the enormous freedom guaranteed to doctors by a law suit in 1957 which ruled that, “if a doctor reaches the standard of a responsible body of medical opinion, he is not negligent”. This so-called Bolam test, named after the patient who lost in court, could be undermined by Lord Saatchi’s proposals. Robert Francis, who led the mid-Staffs Foundation Trust inquiries, says, “no evidence has been produced” to show the existing law is defective and indeed the Bill “proceeds from a fundamental misunderstanding” of the law and

ignores the huge advances made in medical science.

Lord Saatchi has indignantly dismissed his medical critics as reactionary bigots who would sacrifice their patients and progress on the altar of their own self-regard, and dismisses his many learned law critics as financially self-interested.

With respect, my Lord, I disagree. We can cut litigation by no-fault legislation or by requiring ombudsman-style adjudication before taking a medical negligence case to court. We can review the long-winded procedures and maybe cut corners in medical trials. And we can certainly remind over-cautious doctors that Bolam is a powerful safeguard. But with all the best PR in the world the Medical Innovation Bill won’t cure cancer. It is much more likely to do harm.

Nick Ross

Author; broadcaster and journalist, London

DEPRESSION AND SUICIDE: The fallacy of prevention



THE INVITATION to write about suicide and depression for HealthWatch in the light of a few prominent recent cases reached me in New Zealand where, by coincidence, I'd just read a new book on the topic. *Sorrows of a Century: interpreting suicide in New Zealand 1900-2000* by Professor John Weaver is so good (and full of 'personal stories') that henceforth, I think nobody should write about suicide unless they have read it.

The reason is that Weaver has, uniquely, looked at the actual inquest documents of every New Zealand suicide in the even years of that century, cautiously relating them to changes in New Zealand society during that time. It's all there: the suicide notes, the statements from families, policemen, doctors, employers and friends; from wives and girlfriends who couldn't stand the drinking or violence any more. Since New Zealand isn't very different from Britain and has been through similar social, pharmacological and economic changes, his findings are very relevant to us. Unhappily for medical journalists, who dislike bad news from the therapeutic frontline, his conclusions about the prospects for both individual and general prevention are pessimistic. Having handled many patients who attempted suicide and sometimes succeeded, I've often expressed similar views.

Any activist or journalist demanding more suicide prevention resources in Britain should know the sad story of the organization that most people associate with that activity: The Samaritans. In the late 1960s when Samaritan groups had been multiplying for over a decade, it was claimed that they had significantly reduced suicide rates in towns where they were established. That turned out to be an artifact; the unintended and largely unpredicted consequence of replacing toxic coal gas by North Sea gas. Since 1975 when natural gas became almost universal, suicide rates have done some interesting things but no attempts by British governments, psychiatrists or the growing counselling industry seem to have had any significant and consistent effect. The 2008 study¹ recently cited by Nick Clegg (I am still waiting for his response to my questions) is not widely known and covered only patients receiving specialist treatment for depression. It also focused heavily on gun ownership. Most British suicides are in neither category.

"Some impulsive suicides are fuelled by intoxications but it was a Labour government which, despite specific warnings, extended drinking hours and failed to introduce minimum pricing for alcohol"

As with gas, replacing barbiturates with relatively non-toxic alternatives changed the commonest method and may have reduced suicide numbers but it was a British Medical Association initiative, not a political or psychiatric one. Putting barriers near popular jumping-off spots might save a few lives in the short term but hanging is now a leading method and we can't ban rope. The internet provides several alternatives for the sufficiently curious or desperate. Some impulsive suicides (including Robin Williams's, allegedly) are fuelled by assorted intoxications and addictions but it was a Labour government which, despite specific warnings, extended drinking hours and failed to introduce minimum pricing for alcohol. We should expect little from short-termist politicians desperate for re-election.

More antidepressants are certainly not the answer. In the 1970s, Michael O'Donnell published a piece by me in *World Medicine* in which I argued that far more people had been killed by overdoses of drugs prescribed to make them happy than could conceivably have been diverted from suicide by antidepressant prescribing. I was too

kind, for in the 1990s, it became increasingly clear that antidepressants probably had no positive effect at all on suicide rates. Nor, probably, did better psychiatric services. The only evidence-based exception is lithium for genuine manic-depressive illness (not the over-used 'bipolar' diagnoses currently fashionable) and that is not a common cause. Schizophrenics became increasingly prominent in the suicide figures after the 1970s asylum closures and even back-up antipsychotics like clozapine may only slightly reverse that trend.

Weaver's message is that most people who attempt and commit suicide, especially when not acting impulsively, have valid reasons for feeling persistently miserable and hopeless. These reasons typically include both common misfortunes and the sort of common personality-types and world-views that cannot, in his view and mine, properly be called pathological, or be easily changed. Of course, most people who experience prolonged youth unemployment, job loss or romantic disappointment don't attempt suicide and precisely because these factors are so common in both the suicidal and the non-suicidal, they hardly help us to identify those at risk. The sensitive or pessimistic personalities and world-views that are important contributory factors are also common but the final straws that lead to serious suicide attempts are often highly individual events and experiences. Their crucial and lethal importance to those particular individuals is often apparent only with hindsight.

UNEMPLOYMENT increases suicide and full employment diminishes it, especially among youngish men: that much seems fairly certain. The increasing shortage of unskilled industrial or agricultural jobs is a feature of all developed societies and seemingly puts young men at particular and troubling risk of losing their sense of manhood, especially when women are increasingly seen as more attractive employees. Young male suicides increased both here and in New Zealand from the 1980s to the early 2000s; young female suicides did not increase as much. The decline of traditional family structures which, like more sexual equality, really got going in the 1960s, means that these vulnerable young men may lose out even more than women from unstable family life and poor male role models. Even if you don't like those changes, there isn't much in the short term that democratic societies can do about it, or about their damaging unintended consequences. Allowing more skilled, more enthusiastic and sometimes more attractive immigrants to compete for those scarce jobs cannot exactly improve the situation.

Revolutions have losers as well as winners and those particular revolutions have devoured at least some of their children. Although Weaver warns against over-interpreting differences in national suicide rates because of differing definitions and reporting methods, it's fair to point out that egalitarian welfare states like Norway have suicide rates that are probably higher than in England. (Scots are consistently more suicidal than Sassenachs: there's an article there.) Irish suicide rates were suspiciously low until the 1980s but are now at Scottish levels. That's probably due more to increases in honesty than in suicide. Irish coroners no longer rule that the deceased was

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A HOW-TO GUIDE FOR IMPOSSIBLE SITUATIONS

ABC of domestic and sexual violence

Edited by Susan Bewley and Jan Welch

Published by Wiley-Blackwell, Chichester, 23 May 2014. 119 pages RRP £21.99 (paperback), £20.89 (Kindle)

ISBN: 978-1-118-48218-6

ON THE FACE of it, the ABC series seems an unlikely place for a book about domestic and sexual violence. Wiley's ABC guides comprise a collection of some 80 titles, all highly illustrated, packed with diagrams, case histories, colour photographs and easily-digested text, written by specialists for non-specialists in primary care and covering subjects such as dermatology, kidney disease and resuscitation. But domestic violence, a complex, psychosocial issue that is often not even included in the training of health care professionals? Well, it seems to me that the publishers are to be congratulated for taking the bold step of putting some new and potentially life-saving skills into the hands of primary care-givers.

The scale of the problem and its impact on health services alone justifies this subject being included in the series. According to the Crime Survey for England and Wales, the most reliable source of estimates of prevalence within the community, 31% of women and 18% of men will experience abuse from a partner in their lifetime. Intimate partner violence is not a private matter. A burden-of-disease analysis (in Australia) reported that interpersonal violence contributed 8% of the total disease burden in women aged between 15-44, making it the main cause of death, disability and illness in this age group, way ahead of harms resulting from drug-taking, smoking or obesity.¹

But most importantly, this book's intended audience of primary caregivers—GP's, nurses, health visitors, midwives, social workers, paramedics, even dentists—have unique and privileged opportunities to be able to identify abuse and so have a chance to begin to help this vulnerable group of patients, if only they could know how and, crucially, have the confidence to ask the difficult questions.

This slim volume applies the ABC series' approachable and user-friendly format to a series of essays by a multidisciplinary range of contributors which take an evidence-based and practical look at a wide range of aspects of gender-based violence, including that within intimate relationships but also covering forms of violence linked to particular ethnic or social groups, for example, female genital mutilation, prostitution and sex-trafficking. The focus is not exclusively on women—there is a chapter on the sexual assault of men and boys; violence in same-sex relationships is also considered. However the greater emphasis on women reflects evidence showing that the most consistent risk factor for domestic and sexual violence is being a woman; most severe domestic violence and most sexual violence is perpetrated by men.

Each essay is broken into digestible sections, with diagrams, checklists, myth-busters, and case histories with "what would you

do?" exercises. The section on identifying abuse, for example, includes sample questions, suggestions for when and where to ask, and practical tips for ways to overcome barriers to disclosure. Elsewhere there is clear guidance on subsequent medical and psychosocial interventions. Legal issues are explained, including how to document cases; care pathways, professional boundaries, emergency medicine, and where to go for help and advice.

As you would hope from a guidebook, it does not shy away from being prescriptive. To the obstetrician: "You must ask every pregnant woman about domestic abuse; do not make the mistake of thinking that someone else (e.g. the midwife or GP) will have asked." No misunderstanding there—now you know where your responsibilities lie there's no way to justify looking the other way, whether from a disinclination to offend or embarrass or through fear of getting involved in an unpleasant situation.

Earlier reviews on the book's Amazon page show that this guide is roundly welcomed by professionals, but it is difficult to ignore a couple of critical comments from patients. Clearly it is one thing for clinicians to ask questions, but that alone doesn't guarantee they will ask them sensitively and in a way that engenders the trust of the patient and result in a positive outcome in every case. These are very complex and difficult situations, the stakes can be terrifyingly high for the parties involved (including the health professional), and this is only a book. But a book that empowers and compels practitioners to look harder and ask those questions, has got to be a positive step. There may be only one chance to ask a difficult question and ensure the safety of a patient, and it should always be taken.

Mandy Payne

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DEPRESSION AND SUICIDE: The fallacy of prevention

...continued from opposite page

'probably just cleaning the shotgun with his teeth'.

There have been some improvements. People now rarely kill themselves out of fear that they might have cancer. Formerly terrifying diseases like tuberculosis or syphilis are now rather easily cured. The welfare state stops sick and old people from feeling totally helpless and becoming paupers. But that's about all the good news. Parents, especially if they feel guilty about real or imagined parental deficiencies, often demand that 'something must be done' or that 'someone must be blamed'. Apart from obvious and serious parental or organizational failures, history seems to teach that we should strongly resist knee-jerk responses and witch-hunts. Making every child feel wanted and loved and offering them good schools and job prospects seems both common sense and reasonably evidence-based but may be an increasingly utopian idea. British sui-

cide rates are very far from the highest in Europe and have not recently exceeded the previous peaks of the 1930s and 1960s. If very high suicide rates tell us something useful about a society, ask your editors to send you to Finland, Hungary or Lithuania (European leaders) or to Ceylon (leaders in female suicide). The unchallenged international champions are Inuit inhabitants of Greenland, Alaska and Northern Canada. They have reasonable incomes and schools, much alcohol and very little hope.

Colin Brewer

Research director, The Stapleford Centre, London

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Colin Brewer is co-editor, with Michael Irwin, of *'I'll See Myself Out, Thank You'*, a book on medically assisted rational suicide to be published by Skyscraper Books on 29 January 2015.

THIS'LL TURN YOU INTO A FEMINIST

IF IT BECOMES obvious mid-way through a randomised trial that a new treatment doesn't work sufficiently well to make it worth using, stopping early is good practice; we may never get a clear answer, but who cares? But if you're planning on using the new treatment anyway, you really must finish the trial, and sort out once and for all whether it does harm.

Consider a treatment which affects husbands and wives. Treating one automatically treats the other. Evidence accumulates that it is good for the husband but results are unclear for the wife. It would be bonkers to stop when interim data showed a non-significant harmful trend for wives, on the grounds that the treatment was never going to be good for them, and then go ahead and implement it! But that's what the authors of the only trial ever to test the effect of male circumcision on HIV transmission to the woman did.¹

They tested the hypothesis that circumcision of HIV positive men would reduce new cases of HIV in female partners, as part of a larger trial including HIV negative men. When the HIV negative cohort closed, the investigators fretted that "continuation [...] in HIV-infected men could result in stigmatization" and "determined that the conditional power to detect 60% efficacy, [...] was only 4.9% and recommended that enrolment be closed."

At that point 17/93 (18%) intervention and 8/70 (11%) control women had become infected. The difference might have occurred by chance (hazard ratio 1.58, 95% CI: 0.68–3.66, $p=0.287$), but if it was real, wives would surely want to know. The harmful effect is biologically plausible; the foreskin functions as a sleeve within which the penile shaft moves during intercourse to reduce vaginal and penile abrasions. But the trial stopped, and the US, WHO, and the many governments who get funds from those sources, went on to encourage male circumcision, without mentioning the possible increase in female infection risk.²

Some circumcision advocates (example referenced here³) admit that the evidence on male to female transmission is unclear, but conclude "that women will benefit from [...] voluntary medical circumcision programmes in the long-term" on the basis of modelling

studies such as the one referenced here.⁴

But the modelling studies ignore even the possibility of increased male to female transmission. For the base case this one assumed 60% effectiveness for men, 80% coverage by 2015, and no post-circumcision behaviour change. They tested the effect of varying all these in a sensitivity analyses but not the effect of any increased male to female transmission. Am I going mad?

Let's summarise. Randomised trials show that male circumcision reduces female to male HIV transmission by about 60%. The only trial which measured it showed a biologically plausible increase in male to female transmission of 58%, but was stopped before it gave a clear answer. Experts modelled the effect of their programmes assuming the male benefit was real, but ignoring even the possibility of increased male to female infection. On the basis of such models millions of men are circumcised, and millions of uninformed women are put at risk.

It's enough to turn even me feminist!

Jim Thornton

*Professor of obstetrics and gynaecology
University of Nottingham*

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Adapted from Jim Thornton's personal blog of 21 December 2014, with the author's kind permission. Enjoy reading his opinions on examples of questionable science at: <http://ripe-tomato.org/>

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