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ON THE PANEL WITH THE SKEPTICS

THE 16TH EUROPEAN Skeptics Congress was held in September at Goldsmiths College, University of London and featured HealthWatch representatives on the panel. Topics as diverse as the role of the media, terminology, anomalistic psychology, sleep paralysis, and the maths of chocolate fountains made an appearance, before events drew to a close with panel discussion and a fantastic talk from Sense About Science.

James May, HealthWatch's chairman, and committee member Susan Bewley were joined by Edzard Ernst, Catherine de Jong and Maciej Zatonski in a panel discussion that asked what drives people to seek alternatives to conventional medicine, where the boundaries of medical responsibility lie, and whether more skepticism is needed.

Medicine is rendered a victim of its own success by the medicalisation of society, asserted James May. Limitless wants, expectations of pills for all ills, and the overriding dependence on healthcare cannot be sustained. Instead, he argued, we need 'alternatives' that manage illness and underlying causes of ill health. By addressing social issues in policy, investment in prevention could have a much greater impact than today's reluctance to spend until the later stages of disease necessitate a disproportionately higher level. "There is too much medicine and some of it does us more harm than good."

Rather than too much medicine, Maciej Zatonski mounted a robust defence. With a skilled academic community, good research practices, and "probably the best, the most regulated and robust scientific procedures in the scientific world today" medicine is the best it has ever been, with everyone benefiting.

Susan Bewley noted that, while problems do exist, excellent work is taking place and answers are being found through transparency, getting to the data and uncovering the science. However, in what conventional medicine is lacking; be it in kindness or com-

passion, in avoiding talking about real problems and abuses, or challenges and the realities of pain, disability and death; a space is created for alternative medicine to offer something else.

Catherine de Jong reiterated an important distinction between medicine, and wellness treatments or lifestyle choices. Massage should not be termed 'therapy', and 'feeling better' should not be confused with an actual improvement to health. To address the gap between expectation and delivery, doctors "should give patients the attention they need", with de Jong preferring to spend an hour edu-

cating a patient than leave them to go to an alternative practitioner. "I think it is our task to educate the patient and explain and if it takes time, it takes time".

"I think it is our task to educate the patient and explain and if it takes time, it takes time" Catherine de Jong

Zatonski agreed that an initial investment of an hour would not be time wasted.

May emphasised that doctors need to appraise complex factors to understand what has brought a person in to see them. If a doctor treats the symptoms without understanding and addressing a patient's real concerns, they fail; and if a patient's expectations remain unmet, some may be driven to seek alternatives.

To consult effectively it is essential to make optimal use of the limited time available. With time in short supply, techniques of consulting, communication, motivational interviewing—even donning a stethoscope with particular flourish—could help to achieve this. If not, Tudor-Hart's inverse care law—where the most wealthy and

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The return of the Medical Innovation Bill

LORD SAATCHI'S Medical Innovation Bill, defeated soon after it was the subject of the HealthWatch debate in March, was brought back in the 2015/16 parliament and remains pending in the House of Lords. A new version, endorsed by Lord Saatchi as the handing over of his Bill, is also being taken forward in the House of Commons by Chris Heaton-Harris, MP for Daventry.

The Access to Medical Treatments (Innovation) Bill 2015 replicates large sections of its ill-defined and widely opposed predecessor. With such similar drafting to the Saatchi Bill, the same serious risks for good clinical practice, meaningful research and patient safety remain.

The new Bill's second reading took place on 16th October, and a motion has been proposed to suspend Standing Order 46, bypassing

any further Lords scrutiny. If this passes on 30 November 2015, the Bill will be rushed through all stages in the Lords in one day.

You can make your views on the Access to Medical Treatments (Innovation) Bill known to your MP by contacting them via: <https://www.writetothem.com>

Sofia Hart

Journalist and HealthWatch Committee Student Representative

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The ugly truth: Sense About Science lecture 2015

“**W**HAT IS TRUTH? Truth is not one and whole, it’s complicated, varied and contradictory.” So began the 10th annual Sense About Science lecture, on 28th September 2015. The British Library auditorium was filled to capacity with a guest list that read like the Who’s Who of science and journalism. The 40-minute lecture was presented by Tracey Brown, director of Sense About Science, after which the audience participated in a lively discussion chaired by the geneticist and BBC Radio 4 “Inside Science” presenter Adam Rutherford.



Tracey Brown, photographed by Richard Lakos, appears here with kind permission of Sense About Science

The truth is hard, Brown explained, and getting at it is complicated by a real fear of challenging established wisdom. Certainty, when expressed by politicians, campaigners and companies, is reassuring and instills confidence, makes for simple and clear messages, whether justifiable or not. Evidence “messes up the message”—one of the toughest questions an interviewer can ask a scientist is “yes doctor, but are you sure?” It is a brave step to admit you are not, to explain that there are caveats, probabilities, error bars. Experts fear their uncertainty could be used against them, says Brown, undermining their credibility.

Yet we need to do better than this if we’re to get the best available knowledge to base our decisions on, whether we are looking to fight crime, global warming or obesity. We need to be ready to put uncertainty out there, explain it, guide the public through it, and teach them to ask questions.

Sense About Science have now had over a decade of persuading organisations to provide their evidence and encouraging the public to ask for it themselves.

Watch the full lecture on the Sense About Science website at: <http://www.senseaboutscience.org/pages/annual-lecture-2015.html> and read Tracey Brown’s accompanying article in the *Guardian*, 28 September 2015: <http://www.theguardian.com/science/political-science/2015/sep/28/can-you-handle-the-truth-some-ugly-facts-in-science-and-sensibility>

NEWS IN BRIEF

GPs IN HERTFORDSHIRE have been told that their local council may stop funding their NHS Health Checks programme mid-contract. *Pulse* reports that Hertfordshire County Council wants practices to stop providing Health Checks as of 20 October. Under the NHS scheme, practices are paid to carry out a vascular risk assessment on patients aged between 40 and 74 years, who have not already been diagnosed with vascular disease, diabetes or renal disease. The scheme has been widely criticised for its lack of an evidence base. It is not clear from the report whether it is cost or lack of evidence that has driven the council’s decision.

Pulse, 17 September 2015: <http://www.pulsetoday.co.uk/your-practice/practice-topics/pay/gps-face-funding-shortfall-as-council-tears-up-health-checks-contract-mid-year/20020102.article>

THE ADVERTISING STANDARDS Authority has upheld complaints against a UK firm who claimed their digital infra-red scans could detect breast cancer. Crosby-based Medical Thermal Imaging Ltd has been asked to stop making unsupported claims that thermography has been approved by the FDA for breast cancer screening, and that there is medical evidence that it can successfully be used for body screening, pain visualization and early stage disease detection, including as a tool for the diagnosis of breast cancer. Thermographic devices portray heat emission from body surfaces as images with each color or shade representing a specific temperature level, but it has not been proven effective as a screening tool for breast cancer and is not a substitute for mammography.

ASA ruling, 9 September 2015:

https://www.asa.org.uk/Rulings/Adjudications/2015/9/Medical-Thermal-Imaging-Ltd/SHP_ADJ_301979.aspx#.VippCkJWilk

STILL ON the subject of breast screening, Peter Gøtzsche of the Nordic Cochrane Centre has published a blistering verdict on the practice. In an essay, “Mammography screening is harmful and

should be abandoned”, he begins by explaining the pro-screening bias in trials that has made it difficult to know the true effects. The essay concludes that all of the promises on which mammography screening has been promoted to the public appear to be wrong. “Screening does not seem to make the women live longer; it increases mastectomies ... There is so much overdiagnosis that the best thing a woman can do to lower her risk of becoming a breast cancer patient is to avoid going to screening, which will lower her risk by one-third.” If screening had been a drug, Gøtzsche believes, it would have been withdrawn long ago. His essay, in the *Journal of the Royal Society of Medicine*, is accompanied by an editorial by Michael Baum: “Catch it early, save a life and save a breast: this misleading mantra of mammography”.

Gøtzsche P. J Royal Soc Med 2015;108(9):341-345

Baum M. J Royal Soc Med 2015; 109(9):338-339

FOR THOSE short on attention span, two 75-second videos teach how to read medical news articles with a critical eye. US website Health News Review is featuring the videos Four Red Flag Phrases In Medical News Articles and How to Read a Medical News Article. They’ve been made by healthcare economist Gary Fradin who aims to use education to reduce overtreatment.

Health News Review:

<http://www.healthnewsreview.org/2015/10/75-second-videos-capture-some-of-our-concepts/>

THE LATEST NEWSLETTER from Friends of Science in Medicine reports on productive discussions on chiropractic. It is hoped that collaboration with groups including the Chiropractic Board of Australia will help to discourage unsubstantiated health claims for the practice.

<http://www.scienceinmedicine.org.au/images/pdf/newsletter11.pdf> or go to <http://www.scienceinmedicine.org.au/>

IF ONLY WE KNEW WHAT WE KNOW



I HAVE JUST discovered I have haemorrhoids. You probably didn't want to know that any more than I wanted rectal bleeding. Even so I mention it because I want to pose a question about privacy, embarrassment, medicine and progress.

First, let me make the point that this is not a debate I think HealthWatch should engage in. HealthWatch was founded on the principle that medical treatment should do what it says on the tin. In other words it should be based on properly tested evidence rather than assertion or belief. Our members are natural sceptics. We direct our efforts at promoting decent science and opposing quackery. And that's probably where we should leave it, keeping HealthWatch focused.

But it doesn't stop some of us, as individuals, from applying those sceptical principles much more broadly. For example, you might have been intrigued about why surgeons wear masks or the evidence that underpinned the NHS ban on doctors in white coats. On my part I've been increasingly unconvinced about some of the central policy and even ethical concepts on which contemporary medicine is based. One of these is the old Hippocratic ideal of patient confidentiality. Of course medical ethics has come quite a way in 2,500 years with a well-established principle that public good can override a patient's right to privacy. There is no NHS rule to prohibit sharing patient records and the GMC now has extensive guidance on what can be divulged and when.¹ In fact the NHS has several schemes which pay clinicians to collect data so it can track treatment outcomes.

But what about the fundamental premise that patient confidentiality is a Good Thing in the first place? It is a principle so deeply entrenched that most people seem to think it is self-evident. Even people I know and admire think that to question the virtues of patient privacy is naïve, dangerous and perverse. Yet as no less an authority than Fiona Caldicott (of the Caldicott review on information governance and the reason every hospital has a Caldicott guardian) has pointed out, "Good sharing of information is as important as maintaining confidentiality."² Forgive me if I repeat that because it is not a balanced view that gets much of a public airing:

good sharing of information is as important as maintaining confidentiality. Much the same point was made by Simon Stephens when he took up his role as chief executive of NHS England. Disclosing records is good for patients and good for the safety and care of the population as a whole. And as the peer and pioneering surgeon, Ara Darzi, observes: "Good records are as essential to good care as the thermometer and the stethoscope."³ As a very basic step, he says, they must be readily available to everyone in the healthcare team. Bruce Keogh, the NHS's medical director, has put it more bluntly: patients are dying because their medical records are not linked.⁴

There will always be a balance to be struck. Personal medical records must be treated "with propriety and respect," to quote the health secretary, Jeremy Hunt. But even he says sharing data much more widely gives us a tremendous opportunity: "to improve safety, to prevent the need for patients to have to repeat themselves to different health professionals, to make care more efficient, and to find new cures and therapies for killer diseases... The prize for achieving this is very great indeed."⁵

If only we knew what we know.

Part of the problem is that the NHS has astonishingly primitive information systems. A data scientist writing in the *BMJ* contrasts the "fragmented and shockingly underused" information collected by the NHS with how supermarkets track goods and customer preferences and so replenish stock, adjust prices and target offers automatically in real time.

erences and so replenish stock, adjust prices and target offers automatically in real time. "Yet decisions the NHS makes often relate to life or death and not just some customers' preferences for strange flavours of baked beans."⁶

But the deeper and more pervasive problem is a cultural one: a fear that someone might find out about our health, or lack of it. We have constructed a whole panoply of law, not least the Data Protection Act, to keep my haemorrhoids secret. Those laws and how people perceive them mean an ambulance crew or hospital can't read the GP's notes, and researchers can't quickly tell from millions of treatments which have been effective and which have caused harm.

But it is not just the proportionality of our secretiveness that I question. It is the concept itself.

What high principle is at stake that we are defending through data suppression; or could it be that we are going along with modish groupthink? As I have pointed out to the *BMJ* myself,⁷ in Norway tax returns have been made public since the 1800s, and it does not seem to have hampered the economy or the fiscal system, nor brought the walls of civic society crashing down. Why should my medical records be any different? Secrecy is secrecy even when dressed up in the more agreeable word 'privacy'. And while there may, on analysis, be some conditions or circumstances that deserve to be kept secret—identifiable personal records of sexually transmitted infections, for example—attitudes are changing. More and more diseases and injuries are becoming notifiable with little evidence that patients are shunning doctors. We need to be cautious,

and we need to trial things where we can, but the direction of travel towards transparency is surely beneficial. How refreshing it is that people now talk openly about cancer, or disorders of their breasts, colons and prostates, and even erectile dysfunction. How

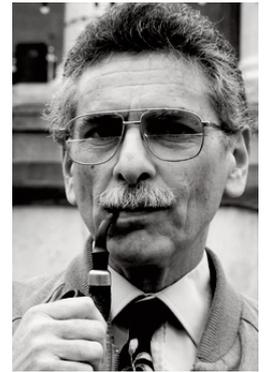
dispiriting it is that we still find it so hard to reveal other conditions, and especially psychiatric problems. Stigma about disease flourishes in the darkness of concealment.

There is another, more immediate, problem about secrecy. My privacy is at your peril as well as my own. Unless we ignore Fiona Caldicott and reject warnings like those from those like Simon Stevens, Bruce Keogh and Ara Darzi, we must accept that medical confidentiality delays progress, causes misdiagnoses, delays treatment, and thereby leads to hurt and death. We can no longer plead ignorance. This should surely cause us all to challenge our understanding of the doctor-patient relationship. It requires us to acknowledge unambiguously that in socialised medicine, epitomised by the NHS, we have exchanged the privilege of being a private customer with the benefit of sharing our risks and burdens equitably. It follows that individual rights, and even autonomy, must be balanced explicitly against the needs, and thus the rights and autonomy, of others. The role of the physician goes well beyond the individual patient to the health of all in their clinical setting and to the wellbeing of society as a whole. The role of citizen in the welfare state goes beyond immediate self-interest to the wellbeing of the community as a whole. In other words, if what seems good for me is bad for you, it should be challenged.

Somehow we need to change the prevailing assumptions so that

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THE FOUNTAINS OF YOUTH: NOT ONE BUT TWO NEW SUPPLEMENTS TO KEEP YOU YOUNG



TWO NEW SUPPLEMENTS on the market claim to extend life and make you more youthful: Niagen™ and Midogen™. Both are marketed by Live Cell Research of California, but oddly only Niagen is listed on their website.¹ According to an email sent out by the company, Midogen was launched on July 24th, and was an instant sell-out. Both supplements claim to increase the formation of mitochondria, and to reverse the effects of ageing.

As we age, we lose muscle, and replace lean tissue with fat—even if our weight remains constant. This loss of muscle tissue is associated with loss of mitochondria—the organelles in the cell that are responsible for energy-yielding metabolism and the formation of ATP to allow us to perform chemical and physical work. What is not clear is whether the loss of mitochondria is a cause or an effect of the loss of muscle tissue. In other words, would increasing the formation of mitochondria, as Niagen and Midogen claim to do, prevent or reverse the age-related loss of muscle?

Niagen is a relatively newly discovered form of the vitamin niacin. Traditionally, we have considered that there are two chemical forms of niacin, nicotinic acid and nicotinamide. The more recently discovered form, which has been trademarked as Niagen, has the chemical name nicotinamide riboside (NR). NR occurs in milk, and possibly other foods.

The role of niacin in the body is to form the coenzymes nicotinamide adenine dinucleotide (NAD) and nicotinamide adenine dinucleotide phosphate (NADP), which have a central role in energy-yielding metabolism. NAD is also important in activating the DNA repair mechanism in response to damage that might lead to the development of cancer, and, of relevance to the “fountain of youth”, it is a substrate for a family of enzyme called sirtuins. Sirtuins were originally discovered in yeasts as proteins that, among other actions, increase the life-span of the cells. Sirtuins have since been found in all organisms that have been examined, including human beings. Sirtuin action in mice and rats (and hence presumably also in human beings) results in reprogramming of gene expression, formation of new mitochondria and improving their function, cell survival and longevity. Transgenic mice that over-express sirtuins have a life-span some 15% greater than control animals.

The availability of NAD is limiting for the action of sirtuins, and feeding mice with NR leads to an increase in intracellular NAD and increased sirtuin activity, leading to improved metabolic homeostasis.^{2,3} However, feeding other precursors of NAD (nicotinamide and nicotinic acid) had the same effect on intracellular NAD and sirtuin activity.³ This is not surprising. There seems to be little, if any, published research on the fate of NR in the intestinal tract. Almost certainly, like NAD in foods, it will be hydrolysed to nicotinamide by digestive enzymes, leading to absorption of nicotinamide, not NR.

The Live Cell Research website¹ makes three claims for the actions of niagen:

Healthy ageing: Niagen “acts as an NAD⁺ precursor and a sirtuin activator, improving mitochondrial activity to improve intracellular communication, and promotes healthy mitochondrial function, which is an important component in human aging.”

To back up this claim the website cites a paper by Denu,⁴ which

they call a study, but which in fact is a commentary on a paper in the same journal⁵ which is a report of the effect of NR on sirtuin activity and longevity in yeast, not mammals. A further report cited in support of the claim involved intraperitoneal injection of NR in mice.⁶ The results showed that raising NAD⁺ levels in old mice restores mitochondrial function to that of a young mouse. However, intraperitoneal injection is a far cry from oral administration of a supplement.

Cardiovascular health: Niagen acts “as an NAD⁺ precursor, it’s been shown to support healthy cholesterol levels induced by a high-fat diet”.

Again a study is cited to back up this claim. This time it is a study of cholesterol synthesis in isolated rat liver cells, and its inhibition by an extract of brewer’s yeast. One inhibitory compound that was identified was NR.⁷

Brain health: Niagen “may support cellular health in the brain by providing an additional safeguard against axonal degeneration”.

The study cited to back up this claim involved isolated dorsal root ganglion neurons in culture. Increasing NAD by either over-expression of the enzymes of NAD synthesis or provision of nicotinic acid, nicotinamide or NR delayed axonal degeneration in these cells.⁸ This is a far cry from providing any evidence that increasing NAD will prevent neuronal degeneration or cognitive decline with increasing age.

So, overall there seems to be little to support the claims being made for niagen to reverse aging in human beings.

There is one human trial, according to a press release from ChromaDex, the manufacturers of Niagen issued in February 2015.⁹ The press release tells us: “the initial results of the first human clinical study for the company’s NIAGEN® nicotinamide riboside (NR) has met its primary endpoint. The results demonstrated that a single dose of NR resulted in statistically significant increases in the co-enzyme nicotinamide adenine dinucleotide (NAD⁺) in healthy human volunteers. The study shows for the first time a similar conversion of NR into NAD⁺ as has been shown in prior animal studies”. We are told: “NAD⁺ metabolomic analyses were completed in blood for various time points over a 24-hour period. For the first time, the study also established an effective dose range for NR in humans. The full results of the study will be submitted for peer review in the scientific literature”.

So, we know that NR is a precursor of NAD in human beings. However, we are not told whether this effect is any greater than an equivalent amount of nicotinamide. And we do not know whether increasing the blood concentrations of NAD and its metabolites (over a 24 hour period following a single dose) has any long-term effects. I look forward to seeing the published paper in due course.

Midogen has three active ingredients: pyrroloquinoline quinone (PQQ), NADH and resveratrol. PQQ was discovered in the 1980s

“The resveratrol source in most supplements is Japanese knotweed—how interesting that someone has found a commercial use for this very invasive non-native plant that we would not like to find in our gardens”

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as a novel cofactor in a number of bacterial enzymes. At the time there was excitement that it might also be a cofactor in mammalian enzymes, but none has been identified. Small amounts of PQQ occur in foods, and small amounts are found in human tissues, but it has no known physiological function. More recently, it has been suggested that PQQ is a vitamin, with a role in at least one enzyme of lysine metabolism.¹⁰ However, this was based on structural similarity between the mammalian enzyme and bacterial enzymes that use PQQ, and there is no evidence that PQQ is involved in the mammalian enzyme.^{11,12}

A recent review by Akagawa and coworkers¹³ cites a study of the effects of PQQ supplementation in people with “forgetfulness” showing improvement over time, but goes on to state that the placebo group showed same improvement over time. Unfortunately, although a number of web sites selling PQQ supplements cite this paper (Koikeda T, et al. Pyrroloquinoline quinone disodium salt improves higher brain function. *Med Consult New Remedies* 2011;48:519), I cannot find it and not even the abstract is available in PubMed or Web of Science.

There is more information on PQQ at <http://examine.com/supplements/pyrroloquinoline-quinone/> and at <http://www.chris-anthony.co.uk/myresearch.html#pqqvit>. The take-home message is that there is no evidence to regard it as a vitamin; it may act as an antioxidant, and animal studies show it increases proliferation of mitochondria, but there is no evidence from human studies.

NADH is the reduced form of the coenzyme NAD. It is unstable in air—it is rapidly oxidised to NAD⁺. However, whether in the oxidised or reduced form, it will be hydrolysed by digestive enzymes, leading to absorption of nicotinamide. So, adding NADH to a supplement will have no more effect than adding nicotinamide.

Resveratrol is one of the potentially beneficial polyphenols found in red grape skins and other foods. The source in most supplements is Japanese knotweed—how interesting that someone has found a commercial use for this very invasive non-native plant that we would not like to find in our gardens. Resveratrol is an antioxidant, but the consensus is that it is too soon yet to accept claims for anything other than antioxidant action.

The Quackwatch website¹⁴ concludes its article on resveratrol by saying “Epidemiologic studies can find associations between the consumption of foods or dietary supplements and various health outcomes. Animal experiments can demonstrate what can happen in the species tested. However, only human clinical trials can determine whether supplementation is useful for humans. Most clinical trials of other antioxidants have failed to demonstrate the benefits

suggested by preliminary studies. Some substances—most notably beta-carotene—have even produced adverse effects. Prior to 2010, resveratrol had not been tested in clinical trials. Since that time there have been some, most of which were small, short-term (a year or less), and designed to evaluate possible therapeutic effects rather than disease-preventive effects. A trial to evaluate preventive effects would need to be large and lengthy and would therefore be extremely expensive”.

A systematic review¹⁵ concluded that, “the published evidence is not sufficiently strong to justify a recommendation for the administration of resveratrol to humans, beyond the dose which can be obtained from dietary sources.”

So, the bottom line is that to date we do not have a supplement that will reverse aging, and keep us young and healthy.

David A Bender

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If only we knew what we know

wider sharing of personal data is regarded as less of a threat and more as a social responsibility. We need to change the default setting from assuming concealment to a presumption of openness, except in specific circumstances or unless individuals explicitly dissent.

No one expects a sudden or dramatic change. But surely we ought to keep questioning—we could do with a debate.

You don't have to take an interest in my piles—I really don't expect you to—but since my discretion can be to your detriment, we should surely do more to question the basic concept of medical confidentiality.

Nick Ross

Broadcaster, author and journalist

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Ethical drug promotion: an oxymoron?

ON THE SUBJECT of the promotion of drugs to healthcare professionals: claims that “ethical codes for drug promotion are too weak” and calling for “larger fines” for breaches in policies are simply backing further into a cul-de-sac.¹

First, there is no need for drug promotion as it only serves the industry’s natural interest: profit. Solution? Just ban promotion. Regulation cannot be effective as the flow is out of control (\$24 billion on marketing to physicians and \$3 billion on advertising to consumers in 2013) and, spending on marketing is superior to those for research for nine out of 10 big pharmaceutical companies.² Much has already been published on the problems of regulating information from research funded by the industry.³

Second, ‘ethical codes’ seem to be constructed with the purpose of spreading positive myths which contradict the evidence. Such as: “industry plays a valid and important role in the provision of medical education” or “medical representatives can be a useful resource for healthcare professionals”.⁴ With rare exceptions, studies of exposure to information provided directly by drug companies have found associations with higher prescribing frequency, higher costs, or lower prescribing quality.⁵

Last, the scale of illegal marketing activities is well reported: the pharmaceutical industry now tops all other industries in the total amount of fraud payments for actions against the US federal government under the False Claims Act.⁶ Infringements include off-label promotion of pharmaceuticals, and the deliberate overcharging of state health programmes such as Medicaid. Fines such as the \$3bn penalty made against GSK in 2012 for corporate misconduct in the promotion of Paxil, Wellbutrin and Advair may seem huge to lay people but are surely part of the business plan—pharmaceutical industry share prices are barely affected by fines. One solution is to target corporate executives. The Obama administration attempted to force out Forest Laboratories’ CEO, Howard Solomon, from any government contracting, even after the firm pleaded guilty to marketing violations in September 2010. Sadly, the Department of Health and Human Services ceased its calls for resignation and Solomon reached the 27th rank on the Forbes Executive Pay in 2011, from the 100th in 2010.⁷

Action must also come from the bottom as well as the top. Pharma industry booths are always welcomed at medical meetings, with many visitors. In fact, who is the less ethical?

Another problem is the promotion of drugs directly to patients. Hamidreza Mani’s comments on the *Lancet’s* Commission on Essential Medicine included wise concerns for patient education but incautiously advised drug companies “should invest in patient education” and that “one of the indices of their assessment should be their contribution to education.”⁸ But with rare exceptions, studies of exposure to information provided directly by drug companies have found associations with higher prescribing frequency, higher costs, or lower prescribing quality.⁹ The US experience of direct to consumer advertising showed evidence not only of increases in spending but also that clinicians are not receptive to questions arising from it.¹⁰

The spread of positive myths crediting industry with a valuable role in medical education or in informing healthcare professionals—against the evidence—must stop.⁴ How can the pharmaceutical industry can have an unbiased and valid role in education?

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On the panel with the skeptics

least unhealthy get the most time—would apply; and May’s morning clinic of 80 walk-in patients would take three days to complete.

As to whether more skepticism is required in medicine, for Bewley the answer is “undoubtedly yes”. Edzard Ernst emphasised that skepticism must pursue an aim, and for him the aim is to improve healthcare. “For me, it is like breathing” he explained. “I cannot imagine a good doctor who is not skeptical ... you cannot be a good doctor or good scientist if you are not skeptical.”

The thought-provoking chat went on to include industry, placebo ethics, the role of the community, future care models and more. While agreeing the importance of skepticism, and a need for focus and education, a division remained as to where a medical responsibility becomes a social, political, or personal one.

Sense About Science closed on a high note with a call for action, with Dr Chris Peters telling the story behind, and stories of, the ‘Ask for Evidence’ campaign.

Evidence behind research, claims and policies is continually overlooked, downplayed or distorted—be it for marketing and product revenue, ‘good’ reasons such as the simplification of a public health message, or through a tendency to trust and accept an existing norm. ‘Ask for Evidence’ encourages people to ask for

...continued from front page

the facts behind the claims they encounter, and to celebrate where evidence is used well.

Truth is ever evolving in science and research and, while uncomfortable, uncertainty is inevitable. In asking for evidence, people can make the best use of what is available. If claims are not supported by evidence, asking searching questions and drilling to the facts can drive policy change, allay health fears imbued by sensationalised press coverage, and raise accountability. Helping the public, patients and professionals understand and make optimally informed decisions in all sectors, it may even help those so inclined to save money otherwise spent on the latest nano miracle gold weight loss booster sauce, ‘armoured underpants’ or ‘detox’ hair appliance. Asking for evidence is something that everyone can do, and everyone can benefit from. Go to: askforevidence.org

Sofia Hart

Journalist and HealthWatch Committee Student Representative

For more information on the conference see: <http://euroscopic-scon.org/> The video recording of the debate on skepticism and medicine is at: <https://www.youtube.com/watch?v=A4erJFq1Ds0> and <https://youtu.be/xyiuZE5fueo>

NICK CLEGG'S 'ZERO SUICIDE' AMBITION. ANOTHER UTOPIAN IDEA?



WHEN I WROTE a piece for last February's newsletter about the difficulty of preventing suicide, I included a brief reference to a claim the previous month by Nick Clegg (remember him?) that suicide could be completely prevented in the NHS. "Nick Clegg is calling for all NHS trusts to commit to a new ambition for zero suicides in the health service" reported the LibDems website on January 15th.

"We know this kind of approach can work in dramatically reducing suicides." said the coalition government's own website.¹ "A mental health programme in Detroit, USA, which signed up to a 'zero suicide' commitment has reported that nobody in the care of their depression services has taken their own life in over 2 years." It continued: "In the UK, pioneering health workers in Liverpool, the south-west and in the east of England are already re-thinking how they care for people with mental health conditions to achieve this ambition for 'zero suicides' in our own health service." I wrote to Mr Clegg requesting more information. Nobody answered before the newsletter went to press but in March, I had a reply from Norman Lamb, the LibDem Minister of State for Care and Support. Among other things, he wrote that "This is not just about more support for people who have presented with suicidal thoughts. We want more to be done in all areas of society so that people do not get to the point where they consider suicide."

By that time, I had read everything I could find about the Detroit study. For such impressive claims, the amount of information available seemed rather small. It comes mostly from a single team and while their enthusiasm is commendable, their claims need to be independently confirmed. Presumably, that is what the pioneering NHS teams will be doing and I await their findings with interest. I sincerely wish them luck but several of the suggestions seem common-sense rather than revolutionary. For example, the BBC² reported that in Merseyside, they plan to "create a Safe from Suicide Team, a 24/7 group of experts which rapidly and thoroughly assesses patients who are having suicidal thoughts." And also to "improve the care of people who present with self-harm injuries at accident and emergency units, offering them therapies on the spot and following up with them when they go home." The director of the local NHS Trust hoped that "within 18 months there will be a noticeable decrease in the number of patients who kill themselves". Note that he did not expect 'zero suicides'.

The main problem with that 'zero' is that most people who commit suicide are not in contact with psychiatric services. Those who are in contact are obviously a high-risk group, since both depression and schizophrenia unsurprisingly carry a considerably increased risk of suicide and presumably, as in other areas of the NHS, improvements in care are both possible and desirable. However, I am puzzled that 'a 24/7 group of experts' for assessing people with suicidal thoughts is evidently something that needs to be 'created'. In 1980, I worked for a while in an excellent North London NHS psychiatric unit that had just such a team. If necessary, patients were briefly admitted to defuse a crisis but no patient was admitted without seeing a consultant first, often on a domiciliary visit at which immediate out-patient or day-patient care could be arranged. This excellent system, which attracted many overseas observers, meant that many longer and inappropriate admissions could be avoided and as a result, there were always empty beds available for rapid

damage-control.

Apart from beds, the other resource that was comparatively plentiful at that unit was morale. The senior consultant had been there for two decades and had assembled a team of experienced nurses and consultants who enjoyed their work. It was a real pleasure to be part of it. Unfortunately, the hospital's bean-counters noticed the empty beds and declared that they were not needed. When I returned there a few years later, both morale and beds were much less in evidence and all the beds were occupied. Both deficiencies are now routine features of NHS psychiatric units. I do not know how the three NHS experimental services will achieve their aims without more rather than less expenditure, but even a large injection of money will not quickly restore the morale of psychiatrists and nurses driven mad (sometimes literally) by bureaucrats, harassed by litigious patients and their opportunistic lawyers and permanently on the lookout for letters from the GMC. No wonder so many of them took the early retirement on full pension that used to be a perk of the specialty. No wonder the NHS has to recruit so many foreign

psychiatrists and nurses, often on short-term agency contracts, to staff a service where the ability to speak not just adequate but fluent and colloquial English is particularly important if subtle warning signs are to be detected in time.

"When I returned there a few years later, both morale and beds were much less in evidence and all the beds were occupied. Both deficiencies are now routine features of NHS psychiatric units."

One important intervention in the Detroit programme—persuading patients to surrender their guns—is irrelevant to Britain. Unlike the USA, where getting on for half of all suicides are due to handguns, firearms cause only a small percentage of British suicides and many of those involve farmers with shotguns. Hanging is now a leading method and rope is not difficult to obtain. If more depressed patients are referred to specialist units, the increased workload is unlikely to be matched by increases in staff. Interestingly, the Detroit unit used Electro-Convulsive Treatment (ECT) rather generously. I am not one of those who think it a barbaric procedure that should have no place in psychiatric treatment but it is not currently very fashionable in Britain. It is also very labour-intensive.

Modest but welcome reductions in suicide among current psychiatric patients may be achievable by re-inventing that North London wheel. The same cannot be said about the wider goal of reducing suicide in the country as a whole. Other than by reducing unemployment, politicians have not had any obvious effects on our suicide rates.

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SCEPTICISM AND RELIGION

James May gave this address at the European Sceptics Congress, September 2015 (see Sofia Hart's report, pages 1 and 2)



THANK YOU FOR the very kind invitation for me to contribute to this interesting discussion. I am a committed Christian and, since secular humanism says there is no need for beliefs about the divine, there will be disagreement, which is good because this is a debate.

I have five points to make.

1. *Scepticism is science*

Science is characterised by clarity and reproducibility, which leads to consensus within the field. It is clear to the expert, but not simple.

This clarity means that there is no established scientific knowledge that I disagree with. There are scientific revolutions, and scientific knowledge is provisional and therefore held tentatively, so I am fully committed to the consensus of knowledge as our current best explanation.

Clarity often makes it easy for trained sceptics to detect pseudo-scientific claims. However it is not simple and sceptical organisations need to promote the public understanding of science.

2. *Science is not the only field of knowledge*

History, Law, Politics, and Economics are all systematic fields of knowledge of great importance but they are not science.

We re-present the world to each other in various ways. Science provides clear descriptive knowledge of the natural world, the humanities more ambiguous and often intuitive knowledge of the human condition. Ambiguity does not entail either that it is not knowledge, or that it is not important. The ambiguity is because humans are complex, free agents with hidden motivations, and because our knowledge is acquired in complex often non-cognitive ways. Poetry, music, or visual arts often communicate true knowledge far more profoundly and economically than science.

3. *Atheism is not a scientific conclusion*

The theist believes that ultimate reality is personal and that God's mind comes before matter; the atheist that ultimate reality is imper-

sonal and that in the material chain of causation, matter comes before mind. Scientific study of the material world cannot decide which is correct since both suppose a material world.

The atheist philosopher John Gray criticises humanism because materialism does not allow for beliefs such as free will, morality or the idea of progress, and that instead they have been co-opted from Judeo-Christian Religion. He comments, 'Darwin says humans are like other animals, humanists claim they are not.'

4. *Many scientific superstars were religious*

Bacon, Descartes, Galileo, Kepler, Boyle, Newton, Pascal, Faraday and Kelvin were devout Christians.

Inductive logic is probably the central assumption of science – that it is possible to generalise from particular instances. Induction has no empirical foundation, yet belief in a divine rational lawgiver facilitated these scientists to believe in a rational and comprehensible universe and to trust induction in order to derive natural laws.

5. *Christianity teaches us to be sceptical of our selves*

It insists that it is possible to know the truth. Jesus, however, constantly questioned the authorities of his day accusing them of pride and arrogance, which did not make him many friends. Ultimately he asks us to question our selves too. Scepticism should start at home. Scientists can sometimes be guilty of triumphalism and arrogance. Epistemological and personal humility admits that it is possible for us to be both intellectually and morally wrong, which I believe is a very good basis for being a sceptic.

James May

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