SPIRITUAL HEALING

Placebo effect comes with all types of healing

From Professor E. Ernst, FRCP

In writing about spiritual healing (*PJ*, 23 February, p242), Michael Bland asks "how does it work?". This elegantly bypasses the question "does it work?". So, what about some evidence. Our systematic review of all rigorous clinical trials on this subject[1] showed that about 50 per cent of them arrived at a positive conclusion. At least in part, this could be because of publication bias, ie, the tendency for "negative" trials to remain unpublished. Our own randomised clinical trial showed clearly that spiritual healing has a powerful placebo effect but not more.[2] "What is wrong with placebo?", Mr Bland asks. Here I agree with him — placebo effects should be used for the best benefit of the patient. But do we really need to believe in spiritual healing for this? I think not, and I rather advocate researching the placebo response more systematically with a view to helping patients to benefit from it — not just those who see a spiritual healer. After all, the placebo effect comes with all types of treatments — even with those that are more than placebos.

Edzard Ernst
Department of Complementary Medicine,
University of Exeter

REFERENCES

1. Astin JA, Harkness EF, Ernst E. The efficacy of "Distant Healing": a systematic review of randomized trials. Ann Intern Med 2000;132: 903–10.
2. Abbot NC, Harkness EF, Stevinson C, Marshall FP, Conn DA, Ernst E. Spiritual healing as a therapy for chronic pain: a randomized, clinical trial. Pain 2001;91: 79–89.

BADDY CHEMISTS

Scientist on the rubbish heap

From Mr S. R. Carter, MRPharmS

Simon Whitaker wrote a rather interesting article about "Baddy Chemists" (*PJ*, 2 March, p288), those pharmacists that stock "quack medicines". It gets worse: some of them even sell shampoo, hair colours and cosmetics.

Mr Whitaker is of course entirely correct. This not only erodes the standing of pharmacists as scientists, but also as professionals. It saddens me greatly to see how we have allowed our profession to be reduced to tawdry retailers selling any old tat for which there might be a market. The degradation of pharmacy is even more surprising given the great support we continue to receive from central government and the NHS. The funding arrangements have always been fair, with the NHS receiving an excellent service from an extensive network of pharmacies, with a walk-in centre on every high street offering extended hours, delivery services, free advice and information. In exchange pharmacists have been well rewarded with the NHS always ensuring that we are amply funded to maintain a high quality professional service and realising that the service offered in these walk-in centres reduces the workload in general practitioners' surgeries and hospitals, not to mention the amount of free social work carried out by community pharmacists.

However, back to the real world . . .

Pharmacies — especially the smaller independent pharmacies in poorer communities — are at breaking point. They do not want to sell non-pharmaceutical stock but must in order to survive. The NHS milks us like an old cow, always wanting more for less. It panders to the big chains allowing massive discounts, while clawing back every penny from the small independent pharmacies, the very pharmacies that actually give the community service — the Baddy Chemists.

I read repeatedly in the pages of *The Journal* and other professional journals about the brave new future of pharmacy. I read with fascination the ruminations of the Royal Pharmaceutical Society, but nobody is able to tell us how we are going to achieve this great change, and nobody is willing to pay for it. The NHS would rather start a whole new network of nurse-staffed walk-in centres devoid of pharmacists than inject any funding into our existing network. The British Medical Association is playing with the idea of drastically increasing nurse practitioners in surgeries in order to reduce the workload of general practitioners.

We know what we must do if we are to get back the respect of the public and to attain a position at the heart of the New NHS. We must spend time training. Every pharmacist should be spending every spare minute of every day studying. We must become nurses! They are the future. The scientist on the high street is a thing of the past; we are now the scientist on the rubbish heap.

Simon Carter
Datchet,
Berkshire

ADVICE FOR CORRESPONDENTS

Letters for publication can be posted, faxed, or sent by e-mail to letters@pharmj.org.uk and should not normally be of more than 400 words. **The Journal** ***reserves the right to abridge letters and to edit them for clarity and style. Pharmacist correspondents should supply their membership numbers and a contact telephone number should always be given. As a result of changes to the Annual Register of Pharmaceutical Chemists, women correspondents should specify a preferred title otherwise "Ms" will be used.***

Letters are accepted for publication on the understanding that they have not appeared anywhere previously. If the issue is of such significance that the correspondent has simultaneously submitted the letter elsewhere, it is the responsibility of the correspondent to inform **The Journal** ***at the time.***

Letters that are critical of individuals, organisations or companies may be sent to the person or body concerned so that they are given a simultaneous right of reply. In these instances, the authors' identities will not be disclosed until publication, and publication may be delayed.

Anonymity will only be accepted in exceptional circumstances. These circumstances will be at the discretion of the editor and the decision made in consultation with the correspondent.

Advertisement

BADDY CHEMISTS

Injustice to homoeopathy practitioners and the public

From Mr L. N. Collin, MRPharmS

As a pharmacist and practising homoeopath, I must take issue with the Broad Spectrum article by Simon Whitaker (*PJ*, 2 March, p288).

The equating of homoeopathic remedies to "highly priced placebos" does considerable injustice to the tens of thousands of both medical and lay practitioners of homoeopathy worldwide, as well as the general public who, I have discovered, are more interested in evidence-based medicine than scientific arguments. If homoeopathy really did only work by a placebo effect it would be difficult to explain the fact that some patients have strong aggravations following a homoeopathic remedy (indeed, some practitioners regard this as a good sign). Homoeopathic remedies can act in both babies and animals. Homoeopathy can act in unconscious and comatose patients. Sometimes there is no improvement after the first remedy, but only after subsequent remedies. Some patients do not respond to a placebo prescribed allopathically but, ultimately, show an improvement following homoeopathy (after all else fails). However, in terms of evidence-based medicine, one could do no better than cite the cholera epidemic of 1830. "In Russia, of 70 cases treated using Camphor homoeopathically, all were cured. And of 1,270 cases, 1,162 were cured and only 108 died. (The allopathic mortality in Russia was 60 to 70 per cent)."[1] A Dr Perrussel in Southern France found the mortality under homoeopathic treatment for cholera in that year was 5 to 7 per cent; the allopathic mortality there was 90 per cent.[2]

Mr Whitaker's teacher (Mr Robey) would probably still decry homoeopathy because it cannot be explained using our currently understood physico-chemical laws of science. However, much research has taken place in the past couple of years into ultra-high dilutions — or UHDs — and their physical, biophysical and biological effects. This has the potential to turn science and medicine on its head by results which seems to indicate that water molecules appear to have a "memory" with increasing dilutions of solutes.[3]

As pharmacists, in the true interests of our customers, perhaps we need to adopt a more "broad spectrum" viewpoint on this dynamic system of medicine and escape from Mr Robey's rather cramped laboratory conditions.

Lawrence Collin
Westcliff on Sea, Essex

REFERENCES

1. Bradford's Logic of Figures, 1900.
2. British Journal of Homoeopathy 1854; p521 and p686.
3. RR Conte, H Berliocchi, Y Lasne, G Vernot. Theory of high dilutions and experimental aspects. Paris: Polytechnica; 1996.

Vicious circle of remuneration

From Mr A. K. Armitage, MRPharmS

I read with some interest Simon Whitaker's article on "Baddy Chemists" (*PJ*, 2 March, p288). I also noted that he is a locum pharmacist and as such has merely to fulfil his professional obligations during the course of his working day. I am certain that Mr Whitaker treats each pharmacy in which he works as if it were his own business (as all good locums do), but it really does not matter one iota whether this pharmacy makes money, breaks even or loses money, as he will walk away with the same fee.

I am sure there is not a pharmacist manager or proprietor pharmacist (with accompanying mortgages, bank loans etc) in Britain who would not want to fill their pharmacy with "scientific" medicinal products and nothing else, but in reality we need people through the door to purchase what they want to buy, not what we think they ought to buy. And once more we return to the vicious circle of the remuneration argument: for as long as we continue to be poorly recompensed for all the services we provide, we resort to other sources of income or what Mr Whitaker would term "quack cures and spurious remedies" and as such fail to be recognised as true health care professionals.

I am not a locum pharmacist, a branch manager, or a proprietor, but if such products are to be sold, then from where better than a pharmacy where suitably qualified personnel can ascertain the appropriateness of an item for each individual?

Andrew Armitage
Cardiff

An uninformed tirade against homoeopathy

From Mr D. B. Needleman, MRPharmS

When I began to read Simon Whitaker's article under the banner "Baddy Chemists" (*PJ*, 2 March, p288) I thought I was to be treated to a tongue-in-cheek exposition. However, I was wrong. What I got was an uninformed tirade about areas of health care that are obviously alien to him. Thankfully, most of us have a less blinkered outlook with, I hope, a level of scientific curiosity. Simon, the Earth is not flat.

If a debate on science is what he wants then at least make an argument and offer a modicum of evidence. What about the evidence for homoeopathy and herbal medicine? Well, with regards to mode of action, this is still unknown as is true for many chemical drugs including aspirin. Is this a product he refuses to sell?

As for published clinical trials, what about amoxicillin and the hundreds of other "medicinal products" that have never been put through trials? There are in excess of 9,000 on file on the Ciscom network in respect of homoeopathy, which, I am reliably informed, is accessible through the Royal Pharmaceutical Society's information department. Let us also not forget the millions of people cured over the last 200 years or so with homoeopathic medicines and the millions also cured over the millennia by herbal remedies.

Let me now move on to "previously unheard of herbal preparations". Unheard of by whom? Has Simon never studied pharmacognosy? Has he never read any scientific journals that report on the millions of pounds being spent by the chemical giants on research into plant chemicals and herbal remedies in an attempt to replicate in the laboratory the results obtained from the natural plant? Has he never heard of digitalis, St John's wort, cocaine, opium and, again, aspirin? Here are five of the most valuable medicines we now possess; are these also not stocked?

Please, let us have balance in articles and not just propaganda without even any anecdotal evidence.

David Needleman
Dean of Studies
British Institute of Homeopathy

Uninformed statements about homoeopathy benefit no one

From Dr S. B. Kayne, FRPharmS

Although I accept totally that Simon Whitaker (*PJ*, 2 March, p288) has every right to express his personal criticisms of what he chooses to call "alternative medicine" (but which most health professionals prefer to call "complementary and alternative medicine"), I strongly dispute his assertion that the profession as a whole should adopt his views. Merely dismissing homoeopathy as being quackery and including it alongside "fat busters" and spiritualism shows a complete lack of understanding of the discipline. Referral to the House of Lord's Report on Complementary Medicine will show that homoeopathy and herbal medicine are classified alongside acupuncture, chiropractic and osteopathy in "Group 1", characterised as "having established research into their effectiveness and being increasingly provided by the National Health Service".[1]

Mr Whitaker talks about "scientific evidence" without specifying the exact nature of the data he seeks. I assume he is thinking of randomised clinical trials. Yet RCTs are not the gold standard many researchers would have us believe. In the first place RCTs are carried out under standard conditions on a carefully selected population. Patients who self-treat rarely follow these standard conditions so the results may bear little relationship to what happens in practice. How many over-the-counter products have good quality RCT evidence of efficacy available from the manufacturers? Very few. The BNF

advises that expectorants are unlikely to have any effect at all, yet many products containing them are still being sold in pharmacies. Turning to prescription drugs, some RCTs, particularly those for potent chemotherapeutic agents, involve numbers well below statistical requirements.

Mr Whitaker states that "there is also an onus on each and every practising pharmacist to examine the scientific basis of the remedies they advocate and sell". It would appear that there are many orthodox medicines with little or no scientific evidence of efficacy that are being sold daily. Where does that leave us all in community pharmacy?

There is of course another method of measuring outcomes, based on patient perceptions of improvement. This is usually referred to as being a measure of "effectiveness" and often results from our experience of case studies. In fact sophisticated methods have now been developed at Glasgow Homoeopathic Hospital to assess whether non-orthodox interventions work.[2] Evidence is starting to emerge, albeit slowly. In some cases it is possible to predict how long it is likely to take before an improvement can be expected.

I strongly support Mr Whitaker's view that pharmacists, along with their fellow health professionals, have a duty of care towards their patients, and this includes a responsibility for giving correct and appropriate advice. To do this effectively one must have the necessary knowledge and that is why complementary therapies are included in undergraduate and postgraduate education programmes, the latter being undertaken by pharmacists, doctors and other health care professionals in increasing numbers. Uninformed and biased statements are of no benefit to anyone, least of all to our patients.

There is absolutely no doubt that many of the complementary therapies suffer from a lack of good quality research based evidence supporting their use. However, many of the holistic concepts involved are consistent with those advocated by pharmaceutical care programmes and fit in well with our day-to-day activities.[3] It is not just about selling a pill for every ill.

Steven Kayne
Glasgow

REFERENCES

1. Complementary and alternative medicine. House of Lords Select Committee on Science and Technology. 6th report, 1999–2000 (HL123). London: The Stationery Office; 2000.
2. Kayne S. Homeopathic pharmacy. An introduction and handbook. Edinburgh: Churchill Livingstone; 1997. pp171–3.
3. Kayne S. Complementary therapies for pharmacists. London: Pharmaceutical Press; 2002. pp13–17.

COMMUNITY PHARMACY

Ownership is in keeping with professional role

From Mr A. J. Smith, FRPharmS

A major effect of the new contract has been the reduction in the number of independent pharmacies, a fall over the past 10 years of 27.5 per cent. Over the same period, the number of prescriptions dispensed has increased by 36.1 per cent. At 31 March 2001, 50.4 per cent of all pharmacies were independent and the balance consisted of multiples and health centre pharmacies. It is forecast that during 2002 independent pharmacies will be in the minority.

It would appear, because of the preponderance of multiple pharmacies among the businesses which dispense large volumes of prescriptions, that the multiples dispense the majority of National Health Service prescriptions. For example, there are 346 pharmacies dispensing more than 10,000 prescriptions per month and, of these, 222 are owned by multiples.

Another major aspect of the new contract in addition to the halving of the percentage gross profit and the growth in multiple pharmacies, is the rapid growth in numbers of pharmacists who are employed as locums. There are, no doubt, many reasons why pharmacists prefer to be employed as a locum rather than in full time employment in one situation, but I would like to mention a few. For example, because of the restriction on the ability to obtain a new NHS dispensing contract, many young pharmacists find it difficult to open a new pharmacy and even more difficult to afford to purchase an existing pharmacy because of the escalating prices for goodwill. The high salaries paid to locum pharmacists, plus the flexibility of working hours, and the changing environment of working in different establishments, are the other factors which have probably led to the growth in locum employment.

I ask whether it is in patients' best interests to have these constant changes in personnel and whether the system of permanent ownership and management is not more in keeping with the extension of the professional role.

Alan Smith
Waterperry, Oxfordshire

Back to the dark ages

From Mrs A. Morant, MRPharmS

A recruitment advertisement under the heading "part-time" in the *PJ* of 16 February is for a pharmacist to work three days per week, 9am to 11pm, job-sharing with another pharmacist. This, presumably, means that another pharmacist works the remaining three days.

These hours, even with reasonable meal and rest breaks, still equate to a 12-hour working day. At a time when society is demanding higher standards from all the professions, how can this be condoned? One is tired enough at the end of an eight-hour day so how can it be expected that someone will be able to exercise the same high degree of judgement and competence after 12 hours. Furthermore, in the event of sickness, would the unfortunate other pharmacist be expected to provide cover by working four, five or even six days in a week?

Even though the public would like pharmacies to be open around the clock, this is unrealistic, as we all know. Surely, as the profession looks to the future, and the Royal Pharmaceutical Society has been planning for Pharmacy in a New Age, there is a need to encourage employers at least to adopt 20th century practices even if they cannot be persuaded to bring themselves right up to date.

Annette Morant
Edgware,
Middlesex

DIANNE McGROARY (Munro Chemists), replies: We aim to provide a quality, flexible service to our customers. There is a need for late night pharmacy services as the customer numbers and the number of referred calls from the police and accident and emergency department shows.

We had actually filled this position before this advertisement was printed, mainly because these hours suit many people's new, fast-moving lifestyles. We have high-quality support staff at all times. This is a modern purpose-built pharmacy with good amenities for all employees. Contrary to Mrs Morant's belief, we do not expect the other pharmacists to cover illness or holidays; we provide high quality locum cover centrally to all our pharmacies.

BPC

Not prepared to compromise local services

From Mr S. A. Wheatley, MRPharmS

Sadly the Dorset branch of the Royal Pharmaceutical Society will not be represented at this year's British Pharmaceutical Conference to be held in Manchester.

The branch committee has taken the decision that our branch grant of approximately £2,200 is best used to continue to provide local meetings. We calculate that each meeting costs about £400 to stage and we plan to hold six such meetings between now and March 2003. We estimate that the reimbursable expenses (conference fees, travel costs and a daily allowance of £20) incurred by a delegate to the BPC will be approximately £600 and we have previously been able to send two delegates.

We are not prepared to compromise our local services and so, under the new reimbursement arrangements, there will be no funds available to support the attendance of branch members at this year's Conference.

Have other branches drawn the same conclusions?

Stan Wheatley
Chairman,
Dorset Branch, Royal Pharmaceutical Society

ANIMALS IN RESEARCH

What is the justification for the use of chimpanzees?

From Mr M. H. Espley, MRPharmS

Perhaps I could ask a question in response to the article about the use of animals in medical research (*PJ*, 26 January, p88). Most pharmaceutical companies are multinational corporations and I suspect that much of their research is done outside the United Kingdom. However, what is the justification for the use of about 2,000 chimpanzees imprisoned in laboratories around the world (about 1,500 in the United States) in biomedical research?

Recent evidence has demonstrated in these animals high levels of intelligence and an ability to suffer not only physically but also emotionally. Humans are not the only beings to experience joy, sadness and despair; they are not the only beings to know mental as well as physical suffering. Humans are not so different from the rest of the animal world, and this should lead to a new humility and respect.

Perhaps we should learn from wise men such as Carl Sagan who said: "If chimpanzees have consciousness, if they are capable of abstractions, do they not have what until now has been termed 'human rights'? How smart does a chimpanzee have to be before killing him constitutes murder?"

Similarly, Dr Christian Barnard said: "I had bought two male chimps from a private colony. They had lived next to each other in separate cages for several months before I used one as a donor. When we put him to sleep in his cage in preparation for the operation, he chattered and cried incessantly. We attached no significance to this but it must have made a great impression on his companion . . . for when we removed the body to the operating room, the other chimp wept bitterly and was inconsolable for days. The incident made a deep impression upon me. I vowed never again to experiment with such sensitive creatures."

Perhaps the next important stage in this debate would be the removal of section 24, ie, the confidentiality clause, of the Animals (Scientific Procedures) Act 1986, which would allow freedom of information on this important subject.

Malcolm H. Espley
Tattenhall, Cheshire

CHD

Are statins really for everybody?

From Ms P. H. Brompton, MRPharmS

May I draw attention to the full-page advertisement for Lipitor (*PJ*, 26 January, facing p84) which opens in bold type "All patients at high risk of CHD benefit from statins".

The Medicines Control Agency's *Current Problems in Pharmacovigilance* (August 2001) draws attention not only to the withdrawal of Lipobay but states that all statins have been associated with a risk of muscle disorders including myopathy and rhabdomyolysis.

The British National Formulary under "side effects" includes a counselling statement, "advise patients to report promptly unexplained muscle pain, tenderness and weakness".

Deaths attributable to Lipobay notified to the Committee on Safety of Medicines have almost doubled since last year, and the CSM has all the statins under review.

My late father was prescribed a statin (Lipitor) last year and experienced intense muscular pain and elevated temperature two hours after the first dose. The matter was reported to Warner Lambert and the CSM.

Could Warner Lambert therefore justify the words "all patients benefit" in this advertisement? Perhaps many patients do, but certainly not all.

Pamela H. Brompton
York

Dr DAVID GILLEN (Pfizer Pharmaceutical Group) replies: We acknowledge Ms Brompton's comments on this advertisement, which Pfizer has now withdrawn from circulation. By the statement "All patients at high risk of CHD benefit from statins", we were particularly referring to the reduction of cholesterol in such patients. However, we understand that such statements may be open to misinterpretation.

THE SOCIETY

Think carefully about long-term consequences

From Mr G. A. Largue, MRPharmS

Ben Hewitt (*PJ*, 2 March, p287) states that the Royal Pharmaceutical Society should become a trade union. Do we not already have these organisations in the way of the National Pharmaceutical Association, Pharmaceutical Services Negotiating Committee, Scottish Pharmaceutical General Council and Guild of Hospital Pharmacists?

I agree that the Society needs to do more to publicise pharmacists as professionals, but remember that there are pharmacists in other places of work apart from the community, and would these branches of the profession get a fair share of the publicity if all the sectors were represented by one trade union? I do not think so. Also in the community, who would this new trade union be representing? The contractors or the employees?

If the Society becomes a trade union, there will have to be a new regulatory body set up which means us having to pay another fee to another body. Some of us already complain about the fees we pay to one Society. If we have to pay two fees — one to stay registered and another to a trade union — will that not add up to an extra cost to us, the members? There will also be no obligation to sign up to this "trade union" and therefore the Society will no longer represent all of pharmacists.

So, please, before deciding which direction the Society should take, think carefully about the long-term consequences.

Gordon Largue
Keith, Banffshire

Why modernisation is essential

From Mr K. H. Tee, MRPharmS

Is the £1.5m for the Royal Pharmaceutical Society's programme of modernisation money well invested? It is supposed to include ongoing work with the Department of Health to pave the way for "mandatory CPD" and "long-awaited improvements to disciplinary powers". A response as to how these two objectives will benefit the profession and the members in practice will be welcomed. The answer ought to be constructed around a realistic model of a pharmacist working 39 to 50 hours a week with ever increasing workload and ever decreasing ancillary staff and morale.

Koon Hien Tee
Scunthorpe, South Humberside

CHRISTINE GLOVER, member of the Royal Pharmaceutical Society's modernisation steering group, replies: The Council has already announced the workstreams involved in its programme for modernisation of its roles as a health professional regulator across the wide range of activities that define modern health professional regulation. Such a programme is not an option but is essential to the future of the profession, which is why other health professional regulatory bodies are undertaking similar work.

The Government is in the process of creating an overarching council to oversee the health professional regulators to ensure consistency and conformity with modern principles of good regulation. There is an explicit obligation upon regulators to put patients' interests first, to ensure and demonstrate that health professionals are competent and fit to practise and to promote continuous improvement within the professions. Rolling out CPD to all pharmacists over the next few years and addressing the Society's remit, powers and functions will meet this requirement.

In the meantime, if we do not organise ourselves and demonstrate that we are working towards these goals, then others' ideas and standards will be imposed. The £1.5m programme of reform that we have embarked upon is a vital investment in the future of the pharmacy profession.

LETTERS@. . .

Letters intended for publication in *The Pharmaceutical Journal* can be e-mailed to letters@pharmj.org.uk. E-mail correspondents should include a postal address or registration number and a daytime telephone number.