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Trick and Treat

How healthy eating is making us ill

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Extract

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Chapter One

Trick to treat

Medical care is one of the world's largest industries. This chapter sets the scene by detailing widespread corruption, fraud and mismanagement, largely for the benefit of the pharmaceutical industry. Heavily influenced by the drug companies, doctors' training is seriously biased towards prescribing; medical research and publications are rarely independent. There is more interest in wealth than health.

> Western Medicine was founded on deception and, as its behaviour suggests, is motivated by an unquenchable thirst for wealth, not health.
>
> *Shane Ellison*

Every year the amount of money the Chancellor gives to the UK's National Health Service goes up and so do our taxes to provide for it. And every year we hear more and more complaints about falling levels of service, lengthening waiting times for treatment, and worsening levels of hospital-borne diseases. With the billions of pounds we pump into the NHS every year, have you ever wondered why we don't get a better service? The reason seems to be because we *do* pump billions of pounds into the NHS every year.

The *Global Corruption Report 2006*,[1] sponsored by the German government, shows that medical care is one of the most corrupt industries in the world – precisely because of the huge amount of money involved. Bribery of regulators and medical professionals, manipulation of research findings, medicines and supplies going adrift, corruption at the procurement stage, and the over-billing of insurance companies are all daily practices in medicine. The report estimates that the world spends more than three trillion dollars a year on health services. And although much of this goes into the pockets of the corrupt, they are rarely found out. It's almost impossible to put a figure on corrupt practices. Medicine

is so inept that a great deal of money is also lost through inefficiencies and honest mistakes, says the report.

One example of this corruption was revealed at a court case in Memphis, Tennessee, where the jury heard that surgeons had received 'donations' of hundreds of thousands of dollars as a small 'thank you' for carrying out some study or other. The *Journal of the American Medical Association* estimated that drug companies spend $13,000 (£7,360) per year on every doctor in order to encourage them to prescribe one drug or another. With a spend of $19 billion a year on marketing to doctors, this is considerably more than they spend on research. But the drugs sold by marketing them in this way make the companies a great deal more so, for them, it is worth it.

The health industry feeds off illness

The ultimate purpose of any business is to generate profits. Medicine is a business just like any other: it derives its income and profits from the sale of treatments for disease, which in most cases means the sale of drugs. If an industry profits from something, then it has a vested interest in that something continuing. So research into the *prevention* of disease is discouraged and ignored in medicine; the focus is on treatment only.

And if the treatment causes damaging side effects, they will give you another treatment for those side effects. And if the disease doesn't go away (and it probably won't as the cause is rarely addressed), then they will gladly refill your prescription. And if nothing seems to be working, don't worry, they are about to announce that they are coming out with a new, better drug next month. (It will probably be only a slight variation on the formula for an existing one, but this will mean they can get a new patent.) Their PR department will spin a story of a revolutionary breakthrough for the newspapers, who will trumpet the good news on the front page. As a consequence, the public will be convinced that this new drug will bring them health, wealth and happiness, and they will all demand it. Arguments about 'postcode lotteries', where some patients are prescribed it whilst others in more prudent areas are not, will mean that very quickly, the National Institute for Health and Clinical Excellence (NICE), will approve it and soon everyone will have to be offered it. The NHS will then need yet more money to fund the treatment, most of which will go to the drug company.

Couldn't happen, you think? Oh, but it does – all the time.

All ill health has the potential not just to make money, but to make it by the barrow load. Almost daily, it seems, we hear of medical breakthroughs that herald an end to one disease or another. It's been the same for decades, and it's a fraud and a delusion. In spite of the 'triumphs' of

medical science, medicine is far from decreasing human suffering as much as its practitioners would like us to believe.

Paradoxically, in health, epochal discovery has rarely been brought about by medical men. Most of the truly significant discoveries have been made by men who, by standards applicable to their time, could only be considered scientific heretics – men so dedicated and so passionately altruistic that they dared to dream impossible dreams of victory over disease and made those impossible dreams become reality. But the penalty for dreaming such dreams has been severe – derision from their professional contemporaries and the label of fraud, or worse. Medical literature is full of such men.

In the 19th century, Dr Ignaz Semmelweis in Vienna held that germs on doctors' hands caused death in childbirth. He proved it by getting doctors to wash their hands before delivering babies – and the death rate among newborn babies and their mothers plummeted. Doctors refused to see the obvious; Semmelweis went down in utter defeat driven out of his mind into an asylum, and an early death from the very staphylococcus infection that had been killing mothers.

Other heretics included Armand Trousseau, who found that there was an anti-rickets factor in fish liver oil, and Christiaan Eijkman who discovered that eating unpolished rice prevented the dread killer disease, beriberi. And there were, and are, many others. These men were scientists. Scientists aren't like normal men. They ask questions that others are too lazy to research.

The eradication of cholera and typhoid in the 19th century wasn't brought about by medical men, but by improvements in sanitation, clean piped drinking water and better housing. Child deaths from diphtheria, measles, scarlet fever and whooping cough fell dramatically in the early 20th century long before the introduction of antibiotics and widespread immunization. Although other factors helped, most important was the higher resistance of children to disease that followed from better nutrition.

Disease mongering

> 'A LOT OF MONEY CAN BE MADE FROM HEALTHY PEOPLE WHO BELIEVE THEY ARE SICK. PHARMACEUTICAL COMPANIES SPONSOR DISEASES AND PROMOTE THEM TO PRESCRIBERS [DOCTORS] AND CONSUMERS.'

These are not my words; they are from the introduction to an article in the doctors' own *British Medical Journal*.[2] The article goes on to say 'Some forms of "medicalization" may now be better described as "disease mongering" – extending the boundaries of treatable illness to

expand markets for new products.'

The article explains how the pharmaceutical industry has four strategies:

1. Find a benign symptom and persuade doctors that it is a discrete disease with a name.
2. Make people anxious about it so that they seek medical treatment.
3. Make out that the 'disease' is widespread so that doctors will see it in every patient.
4. Get at the health professionals who draw up the medication guidelines; shower them with gifts, foreign holidays and consultancy contracts.

And it describes pseudo-treatments for baldness, osteoporosis, erectile dysfunction, and personal or social problems. One example involved the pharmaceutical giant, Roche, who, in a massive publicity campaign, announced that they had a cure for a hitherto undiagnosed psychiatric disorder suffered by one million Australians: Roche called it 'social phobia'. But 'patients' need not worry; Roche had a cure: their antidepressant, *Aurorix*. For what grave medical condition were one million Australians to take *Aurorix* every day? Shyness!

Other examples of 'disease mongering' include:

- Implying that there's something wrong with a normal function which needs treatment, such as a cholesterol level over 5.2 mmol/L (200 mg/dL). The idea that everyone's cholesterol level must be exactly the same regardless of age, sex or circumstance is quite ridiculous.
- Selective use of statistics to exaggerate the benefits of treatment.
- Using a 'surrogate' end point. This is a very common ploy where a believed 'risk marker' is used instead of the real event. For example, high cholesterol is used as a marker instead of what really matters: a heart attack. The two are very different – and not necessarily related.

The use of misinformation to lead people to believe they have a disease that needs to be treated isn't new: doctors in Harley Street, London, used similar methods long before modern pharmaceutical companies got in on the act. The difference now is that where general practitioners were once a bulwark of scepticism against any trading on a gullible public, for the last 30 years they have been used as a cost-effective marketing tool.[3]

Fraudulent drugs advertising

'Our nation is in the throes of an epidemic of controlled prescription drug abuse and addiction . . . While America has been congratulating itself in recent years on curbing increases in alcohol and illicit drug abuse, and in the decline in teen smoking, abuse of prescription drugs has been stealthily, but sharply, rising,' said Joseph A. Califano, Jr.,

chairman and president of the National Center on Addiction and Substance Abuse (CASA) at Columbia University and a former US Secretary of Health, Education and Welfare.[4]

The CASA report provided shocking findings about the abuse of addictive prescription drugs: 'From 1992 to 2003, abuse of controlled prescription drugs grew at a rate twice that of marijuana abuse; five times that of cocaine abuse; sixty times that of heroin abuse.' CASA notes: 'The explosion in the prescription of addictive opioids, depressants and stimulants has, for many children, made their parents' medicine cabinet a greater temptation and threat than the illegal street drug dealer.'

But the CASA report avoids holding the real culprits of the epidemic accountable. This drug epidemic has been orchestrated by physicians and pharmaceutical companies. It is a consequence of the irresponsible prescribing of controlled prescription drugs which have been widely advertised to entice the public – including impressionable children – to take drugs.

The US is not alone. The Institute for Evidence-Based Medicine, an independent research institute in Cologne, Germany, published a study in 2004 of the advertising material and marketing brochures sent out by drug companies to German GPs.[5] The study found that only 6% of the brochures contained statements about drugs that were scientifically supported, while about 94% of the information in them had no scientific basis. They included cholesterol-lowering drugs, blood pressure drugs, and most drugs used for cancer chemotherapy.[6-8] As drug companies spend billions promoting their products, you might expect them at least to get the science right.

In December 2003, Dr Allen Roses, worldwide Vice President at GlaxoSmithKline, Britain's largest drug company, gave an interview to *The Independent* in which he stated that more than 90% of drugs only work in 30% to 50% of people.[9] Not only was someone from the highest echelons of the drug industry, and a high-ranking academic scientist as well (Dr Roses is leading geneticist at Duke University), admitting that a staggeringly high proportion of what is done in the name of medical science is known to be essentially useless, he was also confirming what others had said. Writing in the *British Medical Journal* more than a decade earlier, Dr R. Smith had asked: 'Where is the Wisdom' in medicine? when he pointed out that: 'Over 80% of all healthcare interventions and technologies have no scientific evidence of effectiveness.'[10]

It is actually worse than this because, as well as lacking benefits, the drugs' side effects are known to cause a wide range of harmful side effects: the drugs companies knowingly market drugs that induce heart attacks[11] and diabetes,[12] cause drug dependency,[13] and trigger violent suicidal and

homicidal behaviour.[14] Not surprisingly, in 2005, the pharmaceutical industry faced more product liability lawsuits than any other industry.[15]

Despite the obvious failures of 'conventional' drugs, pharmaceutical companies have a strong pecuniary interest in staying in business, ahead of the field. They will only fund research into drugs they can patent and sell; they won't put money into substances which are not patentable; and they will strongly oppose any treatment that does not rely on drugs at all – such as the dietary protocol discussed in this book.

When is a gift not just a gift?

In 2000, an article in the *Journal of the American Medical Association* evaluated the impact of the pharmaceutical industry on doctors' prescribing habits.[16] It found that contact with drug companies began while doctors were at medical school and continued at a frequency of about once a week. The pharmaceutical industry pays for vacations; free air miles are awarded based on the number of prescriptions written; medical equipment is given to practising doctors; and all-expenses-paid trips are organized to 'continuing medical education' seminars – with speakers chosen by the pharmaceutical company.

Most doctors apparently don't realize they are being manipulated in this way. Those interviewed for this article said that they believed the information presented by industry representatives was accurate, and that acceptance of gifts did not affect their prescribing practices. However, after contact with pharmaceutical representatives they tended to favour the prescription of new drugs and reduced their prescribing of generic drugs. In hospitals, changes in prescribing practice were still evident two years after physicians had attended a symposium, which demonstrated the long-term effect of drug promotions on prescribing practices at the institutional level.

The 2000 study reinforced a similar study conducted six years earlier.[17] That showed that doctors who accepted funding to attend a drug company-sponsored symposium changed their prescribing practices, and added the sponsored drugs to their repertoire. Doctors who requested the addition of a new drug to a hospital formulary were five times more likely to have received money from drug companies to attend meetings, give speeches and perform research; 13 times more likely to have met with drug company representatives; and 19 times more likely to have accepted money from those companies, compared with doctors who did not request a particular drug. And requested additions were five times more likely to be for drugs produced by the same companies whose sales representatives met with the physicians, than for drugs from other companies.

These practices aren't confined to richer nations. Multinational drug

companies also target doctors in developing countries with bribes of lavish gifts, such as air conditioners, laptops, washing machines, TVs and microwave ovens, as an incentive to prescribe more medical drugs.[18]

It is obvious that drug companies' marketing is highly successful in altering physicians' prescribing habits – which is why doctors should stop seeing these representatives, according to a study published in 1999,[19] highlighting doctors' inappropriate and wasteful use of medications after meetings with sales reps.

Doctors' patients are bought

Before any drugs can be used on people, they have to be tested. But where do you find someone silly enough to be a guinea pig? Easy; the drug companies buy them. One common way is to pay university students who are usually broke to take part. But the drug companies also target medical school researchers' patients. In this case the academic researcher is usually offered a per-patient reimbursement by the drug manufacturer that exceeds the per-patient cost to the researcher. And, of course, the researcher can use this money as he wishes. An article in the *Annals of Internal Medicine* stressed that this situation, besides usually being unknown to patients enrolled in the trials, has the potential of creating conflicts of interest. The paper suggested that this could be avoided by re-directing the extra funding to the medical school rather than to the individual investigator. But it points out that, if this were done, the drug company probably wouldn't get the researcher's cooperation.[20]

The drug companies target academia . . .

Official bodies may also contribute to conflicts of interest. There is little point in focusing solely on conflicts of interest related to the pharmaceutical industry while ignoring other important factors that create bias. While scientific and educational meetings routinely require disclosure of conflicts related to industry, they don't ask for disclosures related to clinical income or government grants, both of which are major factors for professional success and involve financial sums much greater than the gifts from industry. If small gifts can create bias, how much worse might these be?

. . . and charities

A similar practice, conducted quietly but growing in popularity, involves drug companies' involvement in charities, according to an exposé published in the *New York Times*.[21] Private-practice doctors across the US set up such charities, which then receive major donations, often in the millions of dollars a year, from drug companies and medical device manufacturers. Concern is rising that drug company payments to such

not-for-profit, tax-exempt organizations bias treatment decisions, lead to suspect research findings, and provide a forum for conflict of interest and misuse of funds. The charities are also closely linked to the doctors' for-profit medical groups, which typically use the products and devices made by the drug companies funding them.

Drug companies boycott conference following speech

But the drug companies won't play if their ploys are disclosed. In November 2006, a young medical researcher almost stopped an entire conference in New Mexico after her talk about drug company influence on medical education.[22] The speaker, Professor Adriane Fugh-Berman of Georgetown University, told her audience: 'Drug representatives are paid to be nice to us, as long as we cooperate, sustaining our market share of targeted drugs and limiting our continuing medical education lectures to messages that increase drug sales.' At that, one drug company representative said her company would immediately withdraw its sponsorship and no longer support the annual conference; the next day there was a near total exhibitor boycott as only one exhibitor showed up. A physician friend of Professor Fugh-Berman remarked: 'Maybe he missed your talk.'

Fraud in medical journals

The drug companies use even more deceitful methods which compound their duplicity. Trials of new drugs, conducted as they are firstly on animals and then on humans, usually over many years, are hugely expensive. It's understandable that drug companies want to recoup their costs, but what happens when a particular drug doesn't live up to the drug company's hopes and expectations? Do they abandon all that work? It seems that the answer is often, No. According to a well-referenced exposé by Shane Ellison, an internationally-recognized authority on therapeutic nutrition with first-hand experience in drug design, companies use deceit to bypass the usual controls, and medical ghostwriting and 'checkbook science' are the most prominent manifestations of this deceit.[23]

Medical ghostwriting is the practice of hiring scientists with PhDs to write drug reports that hype benefits while hiding side effects. The ghostwriters then bow out and qualified physicians are recruited to add their names as the authors. According to Ellison, the reward for ghostwriters can be up to $20,000 per report; the scientists are rewarded with the prestige of having been published.

This practice is much more common than you might think. The *New England Journal of Medicine* relaxed its conflict-of-interest rules in 2002.[24] The following year Professor David Healy, of the University of

Wales, suggested that half of the journal's drug review articles were written by ghostwriters.[25] Dr Richard Smith, editor of the *British Journal of Medicine* acknowledged that medical ghostwriting was a 'very big problem'. He told *The Observer*: 'We are being hoodwinked by the drug companies. The articles come in with doctors' names on them and we often find some of them have little or no idea about what they have written.' He continued: 'When we find out, we reject the paper, but it is very difficult. In a sense, we have brought it on ourselves by insisting that any involvement by a drug company should be made explicit. They have just found ways to get round this and go undercover.' The deputy editor of the *Journal of the American Medical Association* concurred: 'This is all about bypassing science. Medicine is becoming a sort of Cloud Cuckoo Land, where doctors don't know what papers they can trust in the journals, and the public doesn't want to believe.'[26]

'Checkbook science'

According to Dr Diana Zuckerman of the National Center for Policy Research for Women and Families, Washington, DC, the greatest danger to public health might be 'checkbook science', which she defines as 'research intended not to expand knowledge or to benefit humanity but to sell products.'[27]

Drs Joe Collier and Ike Iheanacho, of the Medicines Policy Unit in London, say that cheque-book science explains why deadly drugs are approved. Drug companies have enormous financial power. They choose the investigators from medical academies and government institutions and in many instances involve them in the collation, interpretation and reporting of data. Akin to medical ghostwriting, this practice allows drug companies to hide the dangers associated with drugs while highlighting benefits.[28]

'Sometimes,' say Collier and Iheanacho, 'their commercially determined goals represent genuine advances in healthcare provision, but most often they are implicated in excessive and costly production of information that . . . can risk undermining the best interests of patients and society.'

As with medical ghostwriting, cheque-book science is extremely common. Universities and similar teaching organizations should be independent and unbiased. But, despite increasing awareness of the potential impact of financial conflicts of interest on biomedical research, many academic professors have personal financial ties to drug makers.[29] Justin E. Bekelman and colleagues at Yale University School of Medicine say that: 'Approximately one fourth of investigators have industry affiliations, and roughly two thirds of academic institutions hold

equity in start-ups that sponsor research performed at the same institutions.'

US government institutions are guilty, too. The National Institutes of Health (NIH) were once considered: 'an island of objective and pristine research, untainted by the influences of commercialization.' Their supposed objectivity influences medicine and health not just in the US but in other countries, including the UK. However, according to an in-depth article published in the *LA Times*, top scientists at NIH also collect pay cheques and stock options from the drug industry.[30] To substantiate this claim, the *LA Times* published a list of scientists and their gratuities from drug companies; the sums involved were up to more than $600,000. NIH officials apparently allow almost all of their own top-paid employees to keep 'consulting' fees confidential. When it comes to disclosing financial conflicts of interest, NIH is reckoned to be the most secretive agency in the US government.

While it is understandable that the drug companies aren't in business for their health, they don't seem to be in it for the sake of anyone else's health either.

The Bayh-Dole Act

You might wonder how on earth this has been allowed to happen. The answer lies in a 1980 amendment to US patent law, called the Bayh-Dole Act. It was the brainchild of President Reagan's science advisor, George Keyworth II. Keyworth had been watching the United States get beaten in world markets by the Japanese. The Act was intended to stimulate advanced technological invention and speed its transfer from university laboratories into private industry, where it could be put to work for the US economy; to allow universities to commercialize products and inventions without losing their federal research funding. It looked like a great idea and several private drug companies contributed billions of dollars of much needed research money to the universities at a time when research costs were increasing dramatically.

This helped to launch the biotech industry and speed several life-saving products to market. It also allowed the pharmaceutical industries to buy the expertise of the best academic clinicians at the medical schools for a fraction of the costs of in-house teams; it ensured lower costs and access to a bigger market for their drugs. The academics not only received the research grant money; they could augment their incomes with $1,000-a-day consulting contracts with pharmaceutical companies, patent royalties, licensing fees, and stock options.

But there was a serious downside: Bayh-Dole has fostered increasingly close relationships between the academics upon whom not just the US

but the world depends for unbiased medical information, and private drug companies which are anything but unbiased.

It is assumed that professional medical journals, which are regarded by the medical profession as their bibles, offer the hard science behind any given drug. This assumption is false. Thanks to widespread medical fraud, medical journals can't be trusted.

Publication bias

There is one further phenomenon to be considered: publication bias. Not all studies produce the result that researchers were hoping for. This is particularly true of drug trials. Drug companies will not normally publish such results, and the medical journals don't like to publish them either. For this reason, only data that appear to convey a benefit will be published; data which are negative will not. This leaves readers with the impression that the evidence for a procedure or drug is all positive, when, in many cases, it may be marginal at best.

Political censorship is even worse than this. Editors of once great journals, such as *Nature*, jump through hoops in order to prevent the publication of critiques of establishment dogma.

The 31 May 2003 issue of the *British Medical Journal* ran no fewer than six articles saying that too many of the published drug studies are no more than industry-sponsored 'infomercials', citing the selective reporting bias whereby only pro-industry studies are published. It suggested that it was: 'Time to untangle doctors from drug companies.' Time, yes, but there is little sign yet that this state of affairs will cease. As a result of this bias the word 'cure' has all but vanished from the medical literature.

Pharmaceutical company bias

The effectiveness of a drug is usually established by a trial of the drug versus a placebo. These trials are expensive and usually funded by manufacturers. But when researchers from the University of California investigated 192 published trials for cholesterol-lowering statin drugs, they found that the results were 20 times more likely to be favourable, and the researchers 35 times more likely to give their conclusions a favourable spin, when the drug company was paying than when the funding was from an independent source.[31] In fact the greater effectiveness of a drug over placebo seems to disappear when tested independently. A systematic search of the Cochrane Database of Systematic Reviews, considered by many to be the most objective medical science reporting of all, showed that all of the industry-funded meta-analyses of drugs recommended the experimental drug without reservations, while none of the Cochrane reviews did so, even though the

estimated treatment effects were the same in both cases.[32] Peter Gøtzsche at the Nordic Cochrane Center in Copenhagen, a co-author of the meta-analyses report, said that he would now ignore any meta-analyses funded by drug companies.[33] But drug trials are worthwhile investments for drug companies for, once a drug has received a favourable review in a so-called 'scientific' trial, it is well on the road to millions of dollars of sales.

This probably wouldn't be the case, however, if the drug companies published their data showing that their drugs were useless or harmful. Not surprisingly, they don't. Whenever a study doesn't come up with the 'right answer', they keep quiet about it. To combat this, the Labour Party's 2005 election manifesto promised to: 'require registration of all clinical trials and publication of their findings for all trials of medicinal products with a marketing authorization in the UK.' However, under EU legislation, it seems that forcing drug companies to publish negative trial results is illegal![34] So we can't even trust those whose duty it is to protect us.

Misleading abstracts

There is one last point that must be made in this context. There are some 30,000 medical journals published throughout the world. No busy doctor can be expected to read more than a handful at most. The papers they contain are often long and complex, so many doctors will simply read the 'abstract' (summary) and, perhaps, the conclusions. It is important, therefore, that the abstract be a true reflection of the paper. It is worrying that a review of the accuracy of abstracts in six of the most prestigious and most read journals found that up to 68% of their abstracts were inaccurate. The authors of the review conclude: 'Data in the abstract that are inconsistent with or absent from the article's body are common, even in large-circulation general medical journals.'[35]

The result

We now have a situation where caring and conscientious General Practitioners and hospital doctors have no way of knowing which drugs or other treatments have any benefit and which may cause harm to their patients. Having to rely on the papers published in medical journals is, for them, fraught with danger. They are caught in a trap not of their making, but which has conferred on them an unenviable reputation as harmers of our health, as we will see later.

And how are their patients to make informed treatment choices if they cannot rely on the efficacy and safety of the treatments that are recommended to them by their physicians?

Health or wealth?

Drugs companies aren't philanthropic organizations and they must make a profit to survive. This means that a treatment which doesn't make money is of no interest to them. Dr Bernard Dixon, writing in the medical journal, *Lancet*, in 2003, asked whether the recent outbreak of SARS in Asia might be treated by the well-tried, century-old technique of 'passive immunity' – that is injecting antibodies derived from infected patients and multiplied in some neutral organism. This method can be greatly improved by modern biotechnology. 'Would it not work?' he asked. A drug company executive told him: 'Of course it would. But we've looked at it and there's no money in it.'[36]

Are new drugs any better than the old ones?

Drug companies make most of their profits from the sale of new drugs; when patents run out, so does their income. New drugs are always launched with a promise that they are far better than the drugs that they replace. And human nature being what it is, we tend to believe this.

In reality, the new drugs are often no better; indeed, they are often only a little different from the ones they replace. It's true that they are usually far more powerful, but that often means they come with an even greater risk of causing a serious adverse reaction.

When a new drug comes on the market, everyone expects the prescribing doctor to report any adverse reactions in his patients. But a new Portuguese study has discovered this doesn't happen as often as it should in Portugal, with less than 10% of the numbers expected according to the World Health Organization.[37] The US, Canada, Italy, Sweden and the UK also have very low reporting rates, say the researchers. Nonetheless, health authorities often recommend newer – and more expensive – drugs even though medical trials consistently discover that they are no more effective, or safer, than the older generations of drugs.

To combat this (we are told) we have institutions such as NICE in the UK and the FDA (Food and Drugs Administration) in the US. But just what is their role? Is it to protect us, the public, or to help the drug companies generate greater profits?

Psychiatrist, Dr David Healy (by now a Professor), from the North Wales Department of Psychological Medicine, writing in the *British Medical Journal*, wanted to know why a drug company had written to him, admitting that its antidepressant, *paroxetine*, might increase the risk of suicide six-fold, while the official data from the regulators painted a far rosier picture.[38] 'Many people expect drug companies to be slow to concede that a drug causes hazards, but we do not expect our regulators to be even slower,' he said.

The reluctance of the drug regulators to issue warnings about drugs happens on both sides of the Atlantic. Dr Healy pointed out that 'every antidepressant licensed since 1987' was associated with a higher risk of suicide compared with placebo, and yet America's drug regulator, the FDA, continued to obscure this vital fact. The FDA was aware that drug manufacturers had tried to muddy the waters by wrongly blaming some suicides and suicide attempts on the placebo rather than the drug itself, and yet had done nothing about it.

Dr Jerry Avorn, writing in the *New England Journal of Medicine*, points out that: 'Since 1992, the United States has relied heavily on the pharmaceutical industry to pay the salaries of Food and Drug Administration scientists who review new drug applications.' More than 40% of the budget of the FDA division that reviews new drug applications is contributed by those drug companies. Avorn tells how colleagues at the FDA are worried that the organization is accountable to the industry it regulates. 'One FDA scientist who was often criticized for being too concerned about drug-risk data was told by his supervisor to remember that the agency's client was the pharmaceutical industry. "That's odd," he replied. "I thought our clients were the people of the United States."'[39] Pressures on the FDA by drug companies to rush the drug-approval process have led to the FDA's regulatory review times being among the shortest in the world.

Consumer, beware

In view of the wide range of harmful side effects, you might expect that compensation should be forthcoming in the event of harm. You would be wrong. So many people in the US have brought lawsuits against drug companies for the harm caused by their drugs that something had to be done. And it probably isn't what you might expect. In February 2008, the US Supreme Court's decision gave the biotech drug and device industry immunity from liability for marketing defective products that kill.[40] American consumers now no longer have any recourse if they are harmed by defective drugs, vaccines or medical devices that carry the FDA seal of approval. That seal of approval is a licence to market even poorly tested, defective drugs, vaccines and medical devices that kill. And these drugs can be used in other countries as well as the US.

So, beware: if you blindly accept and use any prescription drug and it harms you, it's your own fault!

The American model

The main driving force behind American medicine is wealth rather than health. There is plenty of insurance money so doctors have no

compunction about cashing in on it. This, of course, increases medical insurance premiums, which means even more money . . . and so on.

According to a new survey which was conducted for the Commonwealth Fund, a non-partisan foundation that supports research into health and social issues, 40% of adults polled reported having serious problems paying for health insurance or for their own or a family member's healthcare in the past two years. A similar number reported having serious problems getting appointments to see a doctor when they were ill; and that the time needed to handle paperwork or deal with disputes related to medical bills and health insurance was a serious problem. Three-quarters of US adults now: 'believe the US healthcare system needs to be fundamentally changed or rebuilt completely.'

High healthcare costs have long been a problem in the US. With an average household income of $44,000, half of those earning up to $50,000 report difficulties paying for healthcare. There are also concerns that costs are 'moving up the income ladder'; worries about whether they would be able to afford high-quality care when needed were found in groups with incomes as high as $75,000. Not surprisingly, 'the findings indicate that more than half of all households experience stress when paying for medical care.'[41]

The health industry milks the system for all it can get. The British NHS could find itself in similar trouble unless the hold the drug companies have on it is not broken soon.

Approve our drug or else . . .

If anyone still believes the pharmaceutical industry's main concern is to help mankind they might be interested in the way drug company executives lobby UK government ministers. In an exposé, *The Guardian* reported on notes made at meetings between drug company lobbyists and government ministers, which have just been made public under Freedom of Information legislation.[42]

The article reveals bully-boy tactics and threats from the drug company executives to get their new expensive drugs 'fast-tracked' by NICE for acceptance within the NHS. Over the eight months from October 2005 to May 2006, senior executives from ten drug companies met ministers to press for favourable decisions on their products. The executives were highly critical of NICE. Although NICE is an independent expert body the government invariably accepts NICE's final recommendations. At one meeting, the health minister, Jane Kennedy, was confronted by eight managing directors, vice-presidents and senior executives from six drug companies who lobbied hard for a NICE ruling to be overturned by the government; two companies lobbied ministers for wider access by

patients to their drugs, both of which were later turned down by NICE on the grounds that they were not effective enough and too expensive; and Pfizer executives suggested they could withdraw their investment in the UK unless NICE reconsidered its refusal of one of Pfizer's drugs.

This giant US company, with annual revenues of $52.5 billion (£26 billion), suggested that it might 'take its business elsewhere' unless the government helped create a more 'robust' environment for pharmaceuticals in the UK. Richard Marsh, director of external affairs at Bristol-Myers Squibb, who also attended one of the government meetings, said drug companies wanted to invest in countries with a 'favourable environment'.

With a total investment in research and development of more than £3.4 billion in 2004, the pharmaceutical industry is a major contributor to the UK economy. So, in effect, the government is being told it must either approve drugs, without all the time-consuming safety and efficacy checks, or lose substantial inward investment. It's a powerful lobby which has no regard for the patient or the tax-payer.

And it's not just the drug companies that are lobbying for this. It seems that there is also intensive lobbying by the White House to grant American pharmaceutical giants unrestricted access to the UK market. If it is successful, it means every new, approved drug would become immediately available on the NHS as part of a free-market initiative. US deputy health secretary, Alex Azar, has also intimated that the American system of advertising drugs directly to the patient would also be introduced.[43]

. . . and pay a higher price for it

In another story, *The Guardian* reported that GlaxoSmithKline had won a partial court victory in an attempt to block wholesalers from buying its drugs cheaply in Spain and selling them in the UK and other European countries where prices are higher.[44] Drug companies set different prices for their medicines in each country according to what they think the market will stand. It is called 'parallel trading'. Prices in the UK are relatively high, so wholesalers will buy up cheaper stocks in Spain, Portugal or Greece and sell them to UK high street pharmacies at discount prices. This saves the NHS £200m a year. Major pharmaceutical companies, however, argue that it damages innovation by reducing the profits available to invest in research and development (R&D) of new medicines.

Fat cats and your local GP

When we talk of fat cats in industry, few people think of their family doctor. In 2006 a study of tax returns forced a rethink.[45] As the NHS's cash crisis deepened and hospitals shed thousands of jobs, it emerged that GPs' average annual earnings rose by 63% in 2006; some are

earning up to £250,000 a year – the equivalent of ten nurses' salaries.

Whether such huge incomes deliver value for money is subject of much debate. Then Prime Minister, Tony Blair, robustly defended this, saying: 'It's right we make our GPs the best paid in Europe.' He neglected to add that NHS Trusts were concurrently closing wards and sacking staff to balance their books as they ran short of money.

This turn of events may be because of yet another ploy used by the drug companies: according to the *New York Times*, they use governments to endorse and recommend their products. The way they do this is by rewarding physicians with outrageous bonuses and appointments. But not just any physicians; these are the doctors who are on official government panels that set the policy on which drugs will be recommended. It is vital that you understand that this is the way the system operates if you are to resist it.

It was entirely government incompetence combined with mercenary advice from a malevolent drugs industry that led to this sorry state of affairs. The UK's New Labour government seemed more interested in 'targets' than in people's health. It used targets to measure how healthy we were. When the government introduced this method of measuring healthcare, the way GPs were paid changed so that around two-thirds of their income was linked to whether they delivered 'quality services' in certain areas. Targets varied from record keeping to providing a range of clinical services such as cholesterol tests, cancer screens and flu jabs. For the GPs, the more targets they met, the more points they earned, and the more points they earned, the more pounds they found in their pockets. That might not seem like such a bad idea: it would give doctors an incentive to work harder and we would all be healthier as a result, wouldn't we? It hasn't worked that way.

The Quality and Outcomes Framework (QOF) provides 1,050 points for targets across all of the clinical domains, with 550 related to heart disease alone. Each point is worth £124. If doctors manage to get all their patients on all the schemes, that's an extra £126,000 on top of their already not inconsiderable salaries of around £106,000. It's a very powerful incentive for doctors to comply with government targets whether they believe it is doing any good or not. And there's another dimension: with QOF points being written into the national contract and dicta coming from NICE, it is clear that clinical judgement is no longer required; indeed, it will have to be suspended where NICE 'advises' clinicians on best practice. The average physician will depart from 'approved practice' at his peril – the penalties for not toeing the party line being abandonment by his medical defence organization and having no professional support from his colleagues.

We now have healthcare by committee decision, arbitrary order and censure; and the professional wilderness awaits clinicians who dare to use their medical experience and knowledge to question or challenge this orthodoxy.

The UK government defends its policy, of course, saying that it is helping to ensure preventative measures such as health checks take place. And that will make us all healthier and save money in the long term. It's cloud cuckoo land, as we will see in the next chapter.

Patients' groups, underwhelmed by these tactics, complain that GPs are so busy 'ticking the boxes' so that they can earn money for reaching targets that there is little time left for patients' real health problems. Niall Dickson, chief executive of the independent medical think-tank, the King's Fund, says the GPs' contract has not only *not* increased GPs' productivity, it may actually have reduced it.

In the UK, this 'payment by results' scheme has resulted in many GP practices reaching the specified targets. Overall, practices attained 93.2% of the total available points for diabetes.[46] But it's a total waste of money because, as physicians pick up their bonuses, the numbers of cases of degenerative diseases such as diabetes are increasing at an alarming rate.

Whatever happened to the concept of 'First do no harm'?

Another of the reasons for the increase in NHS costs is a constant demand for more and more doctors, nurses and hospitals. Try to close a hospital or even a ward and all hell breaks loose in the local press. But it might be better for our health if, instead of demanding more doctors, we did reduce their numbers. Not only would that cut costs; there is very strong evidence that fewer doctors might actually result in us being healthier.

Doctors strike – and death rates fall

Doctors don't often go on strike, but it has happened sufficiently often for a disturbing trend to be noticed. During the rare times that they have gone on strike – in several countries – the death rate has always gone down.

In 2000, Israeli doctors employed in public hospitals pursued a course of industrial action. This included the cancellation of outpatient clinics and the postponement of all routine surgery. And this limited strike action had some unusual consequences. Throughout Israel, while the doctors were on strike, death rates fell. The coastal city of Netanya has only one hospital whose staff members had a 'no strike' clause in their contracts. As a result, doctors in Netanya continued to work normally – and death rates remained stubbornly the same, failing to reflect the

reduction that was shown in almost all of the rest of the country.[47] And it wasn't the first time; doctors in Israel went on strike in 1973, and reduced their total daily patient contacts from 65,000 to just 7,000. The strike lasted a month and during that time the death rate, according to the Jerusalem Burial Society, dropped by half.

It doesn't just happen in Israel. The 1960s saw physicians in Canada go on strike and the mortality rate dropped. In 1976, in Bogota, Colombia, doctors refused to treat all but emergency cases for a period of 52 days, and in that time the death rate fell by 35%.[48] In the same year the death rate dropped 18% during a 'slow-down' by doctors in Los Angeles. After the strike, deaths rates jumped to 3% *above* normal for more than five weeks as the Los Angeles doctors caught up on their paperwork.[49]

And it is a standing joke among cardiologists that death rates fall during their conferences because fewer of them are attempting to cure moribund patients by doing dangerous surgery. Their treatment can be worse than the disease. It may come as no surprise, therefore, that a major report by Australian medical researchers posed the question 'WILL MORE DOCTORS INCREASE OR DECREASE DEATH RATES?' The report, written by scientists at the Centre for Health Program Evaluation, hypothesized that an increase in death rates in that country was caused by an increase in the number of doctors. Although the report was concerned only with the situation in Australia, there is strong evidence to suggest that this question also needs to be addressed in many other developed countries including Britain and the US.

You may think that the question and hypothesis are outrageous. After all, *Primum non nocere*, 'First, do no harm', is a central tenet guiding medical practice, and most doctors treat this tenet very seriously. Yet the reality is that, with the state of healthcare as it is, our continual calls for more doctors, and expansion of the NHS and our dependence on it, may actually be increasing rather than decreasing illness in our lives. With the world's highest concentration of doctors – one for every 500 people – you might expect that the US would be the healthiest country. Far from it; data from a health survey of the top thirteen wealthiest industrialized countries were published in the summer of 2000. The US came twelfth.[50]

One reason why medical care may increase death rates is the large number of adverse events associated with it. The Australian report mentions a 1995 study of 14,000 hospital admissions. Of those admitted almost 17% suffered an adverse event. One in seven adverse events resulted in a permanent disability and one in 20 of the individuals affected died.[51]

Even that may be an under-assessment. Research on under-reporting of serious adverse drug reactions in the United States and Canada suggests that formal reporting rates may be as low as 1.5% of the real total. US

estimates place adverse drug reactions as the fifth most common cause of death after heart disease, cancer, stroke and pulmonary disease.[52] These figures are not always easy to acquire. It is well known that doctors and hospital consultants are notoriously bad at reporting drug side effects. Although there is a new national reporting system in the UK designed to flag potentially dangerous drugs and remedies, pharmacists said they tend not to report a side effect if patients have been harmed; they are more likely to report only those incidents where a protocol has been broken.[53] They fear that they will be blamed for any side effect, and so feel it is not worth running the risk. Why might they act in this way? It seems that they are ashamed to admit to their patients that they were wrong.[54]

In modern society there is an increasing tendency, typified by the human rights movement, to shame governments, professions and individuals into complying with a particular organization's ideas for social change. Shame is hard to deal with. It engenders embarrassment and guilt; it makes professionals feel flawed. It is, perhaps, no surprise that they fall back on silence. Shame is probably the major reason why most doctors don't report adverse drug effects or change their views on the usefulness and harm of drugs.

A second possibility, which the Australian researchers call 'the dependency hypothesis', is the idea that the more doctors are available, the more dependent on them people become to maintain their health. This leads patients to adopt an exaggerated confidence in the effectiveness of medical care and its ability to offset the harmful effects of their own self-neglect. But that is not a healthy attitude because getting involved with the medical profession can be decidedly dangerous. In 1999, doctors in the US were recognized as the third leading cause of death.[50] Four years later another review had elevated them into first place.[55] The number of Americans killed by FDA-approved pharmaceuticals is equivalent to dropping a nuclear bomb on a major US city every year.

We in Britain are not immune to this trend. On 13 August 2004, an astonishing article appeared on the front page of *The Times*. Based on an independent report published in the *British Medical Journal*, it confirmed that medical accidents and errors were directly blamed for the deaths of 40,000 Britons per year. This made them officially Britain's fourth-biggest killer. But the report went on to state that less than a third of an estimated 900,000 medical mistakes are properly reported each year. The figure also excluded errors committed in primary care such as in GPs' surgeries.

The following year came a Parliamentary Public Accounts Committee Report, *A Safer Place for Patients: Learning to Improve Patient Safety.* It stated that some 22% of medical mistakes that lead to a serious

reaction or even death go unreported in the UK. This is because, while you may read 'the patient died from complications of surgery', the truth is often 'the surgeon killed the patient'. Only one in four hospitals owns up to the patient (or relatives) when something goes wrong; the rest blame it on the disease itself; while just one in 25 drug reactions is ever reported. This massive under-reporting of mistakes is an acknowledged problem. It is usually because of fears of litigation.

Government officials were shocked to hear that nobody knows how many of the reported blunders end in the death of the patient. But based on the known, reported accidents, one in 10 people admitted to a hospital in Britain every year will suffer an incident that will harm them, said Tory MP Edward Leigh, chairman of the Commons Public Accounts Committee. These included 974,000 medical 'accidents'.[56] This is a conservative estimate; government officials accept the figure is more likely to be 1,190,000. We should then add 300,000 hospital-acquired infections, and 250,000 serious adverse reactions to a prescription drug, a figure which is again a very conservative estimate as it is based only on reported reactions – a truer figure may be closer to 1,200,000 every year, according to officials. This means that some 2,690,000 people, or 4.5% of the entire population, could be harmed by medical mishaps every year. 'The numbers of blunders could have been halved if staff had learned from earlier errors,' the report said. Edward Leigh added: 'No public health system should tolerate a failure to learn from previous experience on this scale.'

The lapses cost the NHS (actually, you and me, the taxpayers, of course) an estimated £2 billion in extra bed days and £540 million in litigation and compensation.

All of this may be why the late Dr Robert Mendelsohn, a physician himself, wrote: 'Doctors in general should be treated with about the same degree of trust as used car salesmen.'[57]

However, we do need doctors; no matter how healthy we are, there will always be accidents and emergencies. Doctors are intelligent, good and caring people. Nonetheless, intensely busy and inundated with information and the need to meet government targets, they just cannot keep up. So, hard-working doctors at the sharp end should not be blamed if they get it wrong occasionally. They are being manipulated as much as their patients are.

But when a society's healthcare system is one of the major killers in that society then that system is a failed system in need of immediate attention.

Doctors are the most trusted people in Britain

In view of all that has been written above, you might be surprised to

learn that according to a Mori Poll taken in 2006, an overwhelming 91% of the population voted doctors the most trustworthy professionals in the UK for the 22nd year running.[58] But that might be because the British Medical Association, the UK doctors' trade union, funded the poll.

Do doctors get the wrong training?

If you go to your doctor today, it's extremely unlikely that he will tell you that whatever you have wrong with you is curable. When you use the word 'cure' around him, he will interpret the word to mean 'treat'. His medical school training will have taught him that everything is 'treatable' but practically nothing is 'curable'. For example, take adult onset (type-2) diabetes, which has reached epidemic proportions throughout the industrialized world over the last decade or so. Conventional treatment means taking an increasing number of drugs for the rest of your life as the illness progresses and your health declines. Yet this form of diabetes has been curable for some 70 years. It is also probably the easiest disease both to cure and to prevent, without resorting to drugs, as we will see in Chapter 20.

Your doctor will also never tell you that not so long ago, obesity, high blood pressure, high cholesterol, high blood glucose and insulin levels, strokes, heart failure, poor wound healing, peripheral nerve damage and many other non-contagious disorders were once well understood to be no more than symptoms of diabetes.

There may be two reasons why doctors think in this way. Firstly, there is the drug companies' influence on medical education.[59] Doctors are taught to think drugs, drugs, drugs. Despite this, David Webb, Professor of Therapeutics and Pharmacology at the University of Edinburgh, said: 'Patients are becoming ill and some are dying as a result of poor prescribing . . . A substantial proportion of that is undoubtedly avoidable.' This is because doctors are no longer being taught the basics about drugs and how they work – they are led by drug salesmen, who make great claims for their drugs while underplaying the dangers. It's an alarming situation that is worrying medical students, who have privately expressed their concerns about their lack of prescribing knowledge.

This level of doctors' drug knowledge is especially worrying at a time when drug company hype and influence have reached fever pitch, and when drugs have become more complex and dangerous.

The second training fault seems to lie in the simple fact that, as Dr G. T. Wrench pointed out in the Introduction to his 1938 book, *The Wheel of Health*, during all their years at medical school physicians are taught entirely about disease, not about health:[60]

> 'After debating the question – Why disease? Why not health? – again and again with my fellow students, I slowly, before I qualified, came to a further question – Why was it that as students we were always presented with sick or convalescent people for our teaching and never with the ultrahealthy? Why were we only taught disease? Why was it presumed that we knew all about health in its fullness? The teaching was wholly one-sided. Moreover, the basis of our teaching upon disease was pathology, namely, the appearance of that which is dead from disease . . . By the time, however, we reached real health . . . the studies were dropped. Their human representatives, the patients, were now well, and neither we nor our educators were any longer concerned with them. We made no studies of the healthy – only the sick.'

The experience that Dr Wrench had in medical school has changed little over the subsequent decades. Doctors today still get little or no training in nutrition even though a person's nutrition is probably the most important single factor influencing his or her health.

Hippocrates' admonition to 'Let food be thy medicine, and let thy medicine be food' is as meaningful today as it was two millennia ago.

Drug companies control patients' groups

So, if you can't trust your doctor as an impartial source, who can you turn to? One answer might seem to be an independent patient support group that supplies helpful information and advice on specific diseases. Sorry, that probably won't help either: these groups are also targeted by the drug companies. They call it 'astroturfing'.

The Ekbom Support Group which helps advise people with restless leg syndrome was discovered to have been 'astroturfed' by Glaxo-SmithKline (GSK), the manufacturer of *Adartrel*, a drug for restless leg syndrome. GSK helped Ekbom set up its website and Ekbom was found to be actively promoting *Adartrel*. This underhand trick might never have come to light if the website hadn't started to promote the drug some eight months before it had been approved.

The *British Medical Journal* investigated 28 other support groups. They found that 27 were being funded by drug companies, and were presenting information that was, at best, 'partial'. The journal found they all seemed to be pushing specific drugs to treat conditions, while downplaying risks. The latest is a new pan-European pressure group, Cancer United (CU), which was launched in Brussels on 19 October 2006. It described itself as a pioneering coalition of doctors, nurses and patients, pushing for equal access to cancer care throughout Europe. Many MPs, MEPs and leading figures in European cancer charities, including the head of the European Cancer Patients Coalition, joined CU's board. Then it became clear that things weren't all they seemed to be. It turns out that

CU is merely a front for the drug giant, Roche, which makes *Herceptin*, the new breast cancer 'wonder drug', and *Avastin*. Not only is Roche funding the coalition; a senior Roche executive is sitting on CU's board, and Roche's PR agency, Weber Shandwick, which has been heavily promoting it to clinicians and journalists, is CU's secretariat.[61] Roche's action is further evidence of the pressing need for transparency and accountability in the pharmaceutical industry. A Consumers International study earlier in 2006 found that the top 20 drug companies in Europe all flout their own industry guidelines on corporate social responsibility.

The religion of health

Medical politics has slowly assumed the trappings of a religion whose dogmas we are expected to follow without question. Doctors and nutritionists have become health priests whose verdicts we must accept blindly. School teachers, elected and appointed public health officials, TV and radio pundits, even TV chefs and chat show hosts, have become lay-preachers so that they, too, can help to spread the gospel. People cannot be blamed for acquiescing as many have received this indoctrination since childhood, just as happens in other religions. And anyone who objects or tries to preach a different gospel is ridiculed, ostracized and vilified. This is particularly true of people within the medical profession.

The late Dr Robert Mendelsohn wrote: 'There's no room for compromise because churches never compromise on canon law . . . in medical politics there is a rigid authoritarian power structure which can be moved only through winner-take-all power plays. Historically, doctors who have dared to change things significantly have been ostracized and have had to sacrifice their careers in order to hold to their ideas. Few doctors are willing to do either.'

Many religions are evangelical; 'Health' is no different. It sets out with evangelical zeal to convert unbelievers. In the next chapter, we will see the lengths to which the medical establishment will go to increase its 'congregation'.

Of course, not all doctors are taken in. An Australian doctor, Herbert Nehrlich, summarized the financial aspect in limerick form:

> Any doctor today must have stealth,
> as he deals with his patients' ill health.
> Let me tell you, my friend,
> what goes on in the end
> is a state-sanctioned transfer of wealth.