More On BMA's Approval Of Acupuncture
Author(s): William Asscher, David J. Grant and Mike Cummings
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Letters

We may be in danger of bribing volunteers

Editor—Christie’s news article has highlighted an important inconsistency in the World Medical Association’s fifth revision of the Declaration of Helsinki.1 This fundamental document, first adopted by the association in 1964, defines the ethical and moral responsibilities of physicians and others participating in research on human subjects.

The document insists that all subjects should be volunteers, having freely given informed consent to the research proposed. The latest revision is also particularly concerned with protecting the rights of economically or medically disadvantaged populations, typified by those in developing countries. Paragraph 29 identifies the concept of testing new treatments against the best existing treatment, where such exists, rather than against placebo. Paragraph 30 takes this theme further by saying that, at the conclusion of the study, every patient entered into the study should be assured of access to the best proven prophylactic, diagnostic, or therapeutic method identified by the study. Christie interprets these statements to mean that people in developing countries would at least get access to the best current treatment if they agreed to take part in research into new treatments.2

Economically or medically disadvantaged populations are those in whom the best or most up to date medical services may not be available. If the principles in the revised declaration are put into practice, then those participating will clearly not have freely consented and will not be volunteers (according to Collins Dictionary of the English Language, a volunteer is a person who does some act without being promised any remuneration3). By promising treatments either during or at the conclusion of a research study that would otherwise be inaccessible to the local population, those organising the study would be tempting or coercing subjects into participation. This is precisely what the Declaration of Helsinki is designed to prevent. Although revision and updating of the declaration is important to ensure that it remains up to date, we must be careful not to stray too far from its original goals.

Charles Young lecturer in accident and emergency medicine
Imperial College School of Medicine, St Mary’s Hospital, London W2 1NY
charles.young@ic.ac.uk


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More on BMA’s approval of acupuncture

BMA replies to correspondence

Editor—Moore et al and Kovacs and Gil del Real criticise the BMA’s report on acupuncture.4,5 Our review of the evidence base of acupuncture rested heavily on the comprehensive work of Ernst and White, which summarised the clinical evidence for and against the effectiveness of acupuncture.6

The conclusion of this work is that acupuncture seems to be more effective than sham acupuncture or other control interventions for some conditions, including nausea and vomiting, back pain, dental pain, and migraine. However, for smoking cessation, weight loss, and a range of other conditions the present evidence is unclear. We discussed the problems introduced in basing conclusions on poor quality studies or reports.

Our survey of general practice throughout the United Kingdom showed that acupuncture is the complementary therapy most used by general practitioners, with most patients being referred for pain relief and musculoskeletal disorders. Acupuncture is now reported to be used routinely ahead of physiotherapy and drug delivery systems in 50% of chronic pain services.7

The thrust of our recommendations seems to have been missed. The BMA calls for substantial research funding, the production of guidelines, and a formal appraisal of acupuncture. Kovacs and Gil del Real should note that our recommendation about availability of acupuncture in the NHS was subject firstly to having policies, guidelines, and mechanisms for making this treatment generally available—hence the need for appraisal by the National Institute for Clinical Excellence (NICE). Improvements in training and regulation of non-medical practitioners are required, and doctors need to know the basics of complementary and alternative medicine so that they are better able to advise patients. Our detailed review of safety and adverse reactions to acupuncture should reassure Moore et al that the treatment is comparatively safe—the more important risk is likely to arise through misdiagnosis and the withholding of orthodox treatment.

There are more than 5500 acupuncturists in the United Kingdom, of whom over 3500 are statutory health professionals, an increase of 51% in two years.8 Acupuncture treatment has flourished despite a lack of widespread knowledge of its efficacy, and without comprehensive guidelines for either general practitioners or patients. Recommendations clarifying whether acupuncture should be used in the NHS are urgently needed.

William Asscher chairman
Board of Science and Education, BMA, London WC1H 0JP

1 Correspondence. BMA approves acupuncture. BMJ 2000;321:1220. (11 November.)

BMA report is not wrong

Editor—The letter by Moore et al denouncing the BMA report on acupuncture is couched in strong language, but their account of the report is selective and misleading.9 They ignore its recommen-
dation that acupuncture is effective for nau-
sea and vomiting (particularly postoperative
symptoms in adults), for which there is a sound
body of evidence.1

Moore et al misrepresent the BMA’s position
on smoking cessation; in fact, the report
states clearly that “at present there is no
evidence to support any role for
acupuncture in the management of smoking
cessation.”

Moore et al state: “There is evidence that it
[acupuncture] harms” without reference; in
fact, current evidence shows that the inci-
dence of adverse reactions to acupuncture is
low.2

The evidence remains equivocal on the
use of acupuncture for chronic pain. The
most recent systematic review found that
acupuncture is better than no treatment
(waiting list controls) but that it is premature
to draw conclusions about the effectiveness
of acupuncture compared with placebo or
standard care.3

Performing double blind placebo con-
trolled trials of acupuncture is exceptionally
difficult. Pseudo gold standard evidence,
the BMA accepted the task of dispassion-
ately evaluating the available literature to
define an appropriate role for acupuncture
in the NHS. Its report is not “quite sim-
ply wrong,” and such dogmatism does not
serve our patients or enhance the quality of
debate on this important subject.

David J Grant
consultant geriatrician
Liberton Hospital, Edinburgh EH16 6UB
dj.grant@btinternet.com

Acupuncture techniques should be tested
logically and methodically

EDITOR—Neither the BMA in its report on
acupuncture nor the comments of Moore et
al are entirely right or wrong.4 Lack of evidence
for efficacy does not equal evidence
for lack of efficacy. Obtaining evi-
dence of efficacy for acupuncture has been
hampered by methodological problems
unique to this kind of manual therapy,
particularly that of finding a credible, truly
inert, control procedure. There are now
credible sham acupuncture procedures in
which skin penetration in the control group
is avoided, and the first trial to use such a
procedure indicates a specific effect for
acupuncture.5

Systematic reviews of acupuncture for
back pain have identified several trials that use
different techniques and control procedures.
These would usually be considered far too hetero-
geous to be included in a review. The high-
est quality trials compare needling of classic
acupuncture points with control procedures
that entail exactly the same type of needling
at other points. The intragroup effects in
these trials nearly always indicate a noticeable
improvement after needling; but, inevitably,
the difference between what is described as
real acupuncture and what is described as
placebo is rarely significant. As discussed by
Moore and McQuay, the controls used in
blinded studies of acupuncture for chronic
back pain were 50% effective.6 These controls
entailed skin penetration, so one form of acu-
 puncture was compared with another. A 50%
response rate is typical of effective treat-
ments for acute and chronic pain.7

In their drive for academic rigour, review-
ers are distracted from taking a logical
overview of the subject. There is no evidence
that acupuncture points exist, so subjecting
acupuncture points to rigorous testing is
unlikely to be rewarding. There is a wealth
of evidence, however, that somatic sensory
stimulation can modulate pain.9 Needle
penetration of tissues is a potent form of
sensory stimulation. It is on this basis that
the British Medical Acupuncture Society trains
doctors in an evidence based approach to dry
needling therapy. Safety issues are important,
but for general practitioners or pain special-
ists acupuncture is still probably one of the
safest of the pharmaceutical or pharmacological
interventions they use.

There is a dearth of randomised control
trials with positive results, but this may be
due more to methodological difficulties than
a lack of efficacy. The positive results in lower
quality trials may not be attributable solely
to bias. The pain community would be done
a disservice if acupuncture techniques were
not tested in both a logical and methodo-
logically sound manner.

Mike Cummings
director of education,
British Medical Acupuncture Society
Royal London Homoeopathic Hospital, London
WC1N 3HR
DoI:medical-acupuncture.org.uk

Avoidance of ingestion of anti-inflammatory drugs in dyspepsia is confounding variable

EDITOR—Langman et al in their paper on
the effect of anti-inflammatory drugs on
overall risk of common cancer describe a
method using coded data from the general
practice research database to support their
hypothesis that anti-inflammatory drugs
may protect against oesophageal and gastric
cancer.8 The study reported the association
between a reduction of coded cases of
cancer of the oesophagus, stomach, colon,
and rectum in a subpopulation who had
received at least seven prescriptions in the
13–14 months before diagnosis.9

This conclusion seems to be ambitious as
aetologically it seems unreasonable to
anticipate that the use of a drug in the 36
months before diagnosis will halt a neoplas-
tic process that may have begun many
months or years before. Gastrointestinal
cancer (particularly of the oesophagus and
stomach) is often associated with abdominal
pain and dyspepsia. Patients and their
attending clinicians will avoid the use of
anti-inflammatory drugs in the presence of
such dyspepsia. Thus the reported associa-
tion between the use of anti-inflammatory
drugs near the time of diagnosis is more
elegantly explained by the confounding
avoidance of these drugs in dyspepsia
associated with malignancy.

Langman et al also describe a possible
dose effect, and once again this is equally
well explained by the greater avoidance of
these drugs in patients with increased dyspepsia
rather than by invoking a hypothetical
mechanism of gut epithelial protection. One
of the great advantages of collecting clinical
information in a coded format is that new
associations may be discovered by using
a variety of techniques including knowledge
discovery in databases (P J B Brown and V
Raymond-Smith, unpublished data).10 If
such exploitation of repositories of data is to
gain recognition and acceptance in medicine
vigilance is needed in interpreting these
associations and a full consideration of
possible confounding factors is essential
before proposing new theories.

Philip J B Brown
general practitioner
Hethersett Surgery, Hymble Practice,
Hethersett, Norfolk NR9 1AB
Phil@hicomm.demon.co.uk

1 Langman MSJ, Cheng KK, Gilman EA, Lancashire RJ. Effect of antinflammatory drugs on overall risk of common cancer: case-control study in general practice
research database BMJ 2000;320:1646-6 (17 June).

Risk of torsades de pointes with non-cardiac drugs

Prolongation of QT interval is probably a
class effect of fluoroquinolones

EDITOR—Yap and Camm emphasise the risk
of torsades de pointes associated with
non-cardiac drugs that prolong the QT
interval.1 They comment on the fluoroqui-

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