LOGO

Report on the Enquiry into Fraudulent Practice in the Treatment of Skin Disease

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A report of the
All Party Parliamentary Group on Skin

London
December 1999

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Report on the Enquiry into Fraudulent Practice in the Treatment of Skin Disease

1.0. Background

1.1. The All Party Parliamentary Group on Skin has consistently received complaints from its patient and medical members about what can broadly be described as fraudulent practice in the treatment of skin diseases. The Group decided, in early 1999, to look into the issue of fraudulent medical practice as it pertains to skin disease. It consequently called for written evidence on the subject from its members and other interested parties.

1.2. A specialist advisory committee was established to guide the Group in its enquiry. Members of this committee are listed in Appendix Two.

1.3. A large volume of evidence was accumulated and the report seeks to assess the scale and nature of the problem as well as to recommend ways in which it might be tackled.

1.4. The Group also took evidence from a series of witnesses at two oral evidence sessions in April and June 1999. A list of witnesses is set out in Appendix One.

2. 0. Summary

2.1. The area of fraudulent medicine is a difficult one to investigate and gaining hard evidence of fraudulent practice is a testing challenge. This is because those who have been persuaded into parting with large sums of money for treatment which doesn't work, are generally reluctant to admit to it or to publicise the fact.

2.2. The Group was presented with a great deal of both written and oral evidence, amongst which were enough examples of fraudulent practice to convince it that there is a real and largely unchallenged problem in this area. A number of non-regulated products are marketed openly as offering treatment, or even a cure, for skin disease. These will either have no effect at all or could be positively dangerous for the user. In most cases the treatment is expensive and often sold in a pressured manner to patients who may effectively be bullied into persisting with it.

2.3. No organisation or body in the UK has the powers or the will necessary to deal with vendors of fraudulent skin products or unlicensed and unscrupulous practitioners. The latter generally take care to stay just on the right side of law or operate in a way which makes it difficult to detect or prove where they have stepped over the line.

2.4. The Group has made a number of recommendations for actions which could improve the situation but believes that the whole area should be the subject of a properly structured Government enquiry. This would probably go further than skin disease, perhaps including cosmetic surgery and other areas which are surrounded by similar controversy.

3.0. Definition

3.1. Fraudulent practice in the area of skin disease care is defined for the purposes of this report as: “A situation in which skin care or a skin care product is given, sold or promoted to

an individual with a skin disease or condition but which is either not what it purports to be, or has no proven efficacy and/or safety”.

3.2. Typical features of such treatment are that products are not medically or clinically tested, and/or practitioners are not medically or otherwise suitably qualified. Practice in this area might be well-meaning (although, equally, it might not be) but it is often expensive, ineffective, dangerous or hope-raising without subsequently delivering results.

3.3. The main problems fall into four categories:

- Herbal products sold as “natural” remedies but which contain a synthetic ingredient, for example a potent steroid;
- Situations where patients are not told of active ingredients or other contents;
- No active ingredient and the product does not work;
- A so-called “clinic” makes a diagnosis which is dangerous and fraudulent advice and treatment is given, perhaps by an unqualified practitioner providing a useless product or one containing an undeclared ingredient. Advice could include advising a patient to pursue a dangerously deficient diet.

3.4. Most of the problems associated with the area are at worst inconveniencing, especially if this involves spending a great deal of money on a treatment which doesn’t work. But the Group’s main concern surrounds those circumstances where products, either sold or prescribed, contain an undeclared active ingredient which then causes a severe reaction in the user. Several examples of this were provided to the enquiry.

4.0. Complementary Medicine

4.1. The Group is concerned to make a clear distinction between what it regards as fraudulent practice and the area of complementary medicine. The latter can be highly effective for patients. Complementary medicine is defined as “a group of therapeutic and diagnostic disciplines that exist largely outside the organisations where conventional health care is taught and provided”1. This does not mean, however, that they do not have value.

4.2. The Cochrane Collaboration describes complementary medicine as “a broad domain of healing resources that encompasses all health systems, modalities and practices and their accompanying theories and beliefs”2. It includes a range of disciplines from acupuncture to ayurvedic practice, environmental medicine to herbal remedies and reflexology to yoga.

4.3. A substantial amount of complementary medicine is delivered by conventional practitioners and increasing numbers of medical schools are offering courses in complementary medicine. This is because any such practice which is tested and proven generally becomes quickly absorbed into general medical practice. Furthermore increasing numbers of disciplines involved in complementary medicine, such as osteopathy and chiropractic, are now State Registered and regulated. A limited number of others including homeopathy, acupuncture and herbal medicine are moving in the same direction.

4.4. Complementary medicines are often used alongside conventional medicine (literally complementing it) with the boundary between the two “increasingly blurred and constantly shifting”3.

4.5. The Group’s general view is that those therapies which offer good evidence of efficacy and safety and where the product’s contents are known and are acceptable, might well benefit patients and should be encouraged. Any products which don’t meet these standards raise worrying questions and should therefore be treated with caution.

5.0. Cosmetics

5.1. The Group recognises that there are some political issues surrounding the marketing and promotion of certain cosmetics. This is particularly true in respect of the claims that are made for some specific cosmetics (skin lighteners, anti-

ageing creams, products containing active ingredients, etc) and especially those which fall into the category of what could loosely be termed “cosmeceuticals”. Product labelling is now a statutory requirement but there are unresolved issues around testing and non-disclosure of active ingredients.

5.2. The enquiry decided not to investigate issues around cosmetics believing it to be a separate, albeit related, issue. However, the Group will return to this subject in a future enquiry.

6.0. Extent and Nature of Fraudulent Practice

6.1. It is clear from evidence received by the Group that fraudulent treatments and practices are widespread in the field of skin disease management. Skin patient organisations receive significant numbers of complaints about such treatments and practice. The volume of these complaints is a reflection of the incidence and intractability of skin conditions as well as the severity of the physical, social and psychological effects of many skin diseases.

6.2. The more widespread and intractable a condition and the greater its consequences for the patient, the greater is the number of people claiming fraudulently to be able to treat it effectively or to cure it.

6.3. Substantial profits can be made by those making such claims. They are often prepared to go to great lengths to protect their businesses, such as changing product names when fraud is exposed or engaging expert lawyers to advise them and to defend their activities.

6.4. From the perspective of practising dermatologists there was concern, not only of fraudulence, but overwhelmingly of patient safety. There is increasing awareness of the practice of adulterated herbal remedies with potent, or very potent, corticosteroids. This has particularly come to light in the management of atopic eczema and psoriasis.

6.5. Part of the overall problem appears to stem from the failure of many GPs to devote adequate time either to listen to the concerns of patients presenting with skin diseases or treating these as serious medical complaints. For vulnerable patients, this lack of interest or time by the GP can have very damaging effects.

6.6. Dermatology is often trivialised in general practice (see the Group's 1997 report) and sufficient time is rarely devoted either to getting to the root cause of the disease or to treatment experimentation, which the good management of skin disease often requires.

6.7. Frequently patients are not referred onto specialists who could deal better with the problem. The net result is that many patients turn to other sources of treatment and advice out of desperation. This point was reflected in the evidence which the Group received.

6.8. Equally some patients are guilty both of failing to comply accurately with treatment advice and of impatience. Lack of patient compliance with treatment is a particular issue in skin disease and a major reason why treatment often doesn't work to best effect. Most skin diseases have no cure and treatment is therefore mainly palliative. It can take time to work and relapses occur in a high percentage of cases, especially once treatment is stopped. More should be done to educate patients of the facts and that experimentation may be needed before the best solution is found. Nurses and pharmacists could help with this process.

6.9. Furthermore, it is ironic that mainstream medical treatments undergo intensive testing, passing through rigorous regulatory procedures. They are then prescribed by highly trained medical professionals with years of experience in skin disease. However patients often appear distrustful of these treatments and disinclined to listen to the qualified medical professional. Yet they will flock to purchase untested remedies which are headlined in newspapers as being a "miracle cure" by individuals with no medical or scientific training whatsoever.

6.10. There is no miracle cure for any skin condition. It is also probably fair to say, that if there is a sudden and sustained beneficial response to any non-regulated skin product, the patient should be suspicious that it might well contain an undeclared active ingredient such as a powerful steroid. This message needs to be spread by both Government and the medical profession through the channels they have at their disposal for educating patients.

6.11. It was not possible accurately to quantify the number either of products or outlets which could be accurately described as "fraudulent". Equally, the Group was unable to make an estimate of the number of patients involved. Suffice it to say that a strong impression was gained that the problem is widespread and very much ongoing. Notwithstanding the reluctance of people to admit to difficulties with both products and clinics we received a large number of individual complaints and were informed by patient groups that they had received many more.

6.12. It was clear to the Group that there is a significant and largely unchallenged issue in respect of fraudulent practice which lends itself to a properly structured enquiry by Government. This should examine both the extent of the problem and possible solutions. We therefore urge the Government to undertake this review.

7.0. Specific Examples of Fraudulent Practice

7.1. In the evidence which the Group received, complaints about remedies mainly focussed on a hard core of about five products and a limited number of high street clinics. There was an array of complaints about herbal remedies and especially Chinese herbal remedies.

7.2. Chinese herbal medicine has been shown to be effective in the management of atopic eczema, e.g. Zemaphyte granules. Yet the efficacy of such preparations is highly variable. Adults with atopic eczema and parents of children with atopic eczema are frequently reluctant to use topical and/or systemic corticosteroids for treatment of their disease.

7.3. This reluctance stems mainly from a "steroid phobia" promulgated by the popular press, and to some extent, by general practitioners. It has led to increased reliance on traditional Chinese herbalists. There is an increasing number of well-documented cases, for example, where patients have been furnished with herbal medicines which, on scientific analysis, have been shown to contain dexamethasone, a systemic corticosteroid, unbeknown to the patient, or other potent steroids4.

7.4. Patient safety is a prime concern in these matters because long-term use of systemic corticosteroids can result in a variety of significant, potentially life-threatening, side effects such as Cushing's disease, hypertension, osteoporosis and diabetes.

Psoriasis

7.5. Two particular instances of potent corticosteroid adulteration of topical preparations for treatment of psoriasis have also come to light in this country, namely Skincap and another product which we have called Zx.

7.6. Skincap was a mail order acquired preparation, sold as either cream or aerosol. It purported to contain nothing more active than zinc pyrithione, manufactured by Cheminova. The other, currently the subject of legal action, was a cream preparation which claimed to contain a number of herbal ingredients, including camphor and neem tree oils.

7.7. In both instances patients with psoriasis reported rapid clearance of their psoriasis, sometimes for the first time in their lives. These products cost in excess of £30 per week. As both products produced rapid improvement in psoriasis, patients understandably used them and recommended their use to friends and relatives with psoriasis.

7.8. The Group's view, backed by expert medical opinion, is that treatments which work so effectively give immediate cause for suspicion and, in both instances, independent analysis of Skincap and Zx (in the UK and abroad) indicated that the active ingredient of these preparations was a very potent topical steroid. Highly potent topical steroids are only used in the

management of psoriasis under consultant dermatologist supervision and for no more than two weeks at a time. Patients were using these treatments for weeks or months and, when treatment ceased, their psoriasis frequently relapsed or rebounded to a severe pustular form of the disease that necessitated hospital admission.

7.9. The makers of Zx then changed the name of their product and patients swapped to this treatment believing it to be as efficacious. It did not, however, contain steroids and psoriasis inevitably rebounded.

7.10. It is of concern that in neither case were the companies pursued by the Medicines Control Agency (MCA) or prosecuted. This is seen as a potential loophole for all similarly-minded companies, because there is the potential for very large profits to be made.

7.11. The Group's overall impression was that the MCA is reluctant to pursue companies in this type of situation. We could find no recent instance where the MCA has prosecuted the producer of a preparation for use in skin disease in similar circumstances.

7.12. Governmental attitude towards greater regulation in this area seems traditionally to have been to leave well alone. This now appears to be changing to favour more regulation.

7.13. A recent survey of patients with psoriasis revealed over 69% of patients had tried alternative treatments for their disease5. The annual expenditure on alternative treatment was in the range £100 - £500 per patients.

Vitiligo

7.14. As an example, one woman with vitiligo (an incurable disorder of pigmentation) claimed on the telephone to the Vitiligo Society to have wasted £22,000 at one clinic, but hard evidence is difficult to obtain in such cases.

7.15. Amongst a welter of similar stories, the Group received a written account of a London clinic where one person with vitiligo had been charged £950 for a 50 gram pot of cream with a hand-written label which gave no indication of the ingredients. When analysed, the cream had been found to contain small quantities of steroid (Synalar - fluocinolone acetamide) in white soft paraffin. 250 grams of white soft paraffin can be bought from chemists for about £1. A tube of Synalar costs the NHS about £1.50. The Royal Pharmaceutical Society, the MCA and the General Medical Council took the view that the clinic was acting within the law because the medication had been prescribed by a doctor and private clinics can set their own charges for treatments.

Eczema

7.16. Evidence provided for the enquiry by skin patients and skin patient organisations fell into two categories - oral and written personal accounts of expensive, but ineffective, testing and treatments, and copies of press articles and advertisements extolling the alleged benefits of unusual and unproven treatments.

7.17. Allergy testing by unproven methods can cause damage to patients. Vega testing, kinesiology, hair analysis and other methods of testing for allergies will often produce meaningless results, or may miss true allergies or detect non-existent ones. The National Eczema Society has received numerous enquiries from people who have removed foods from their or their children's diets on the advice of so-called allergy testers.

7.18. Although in many cases food-exclusion has made no difference to the skin condition, people will persist with such diets for long periods. This has the potential to damage health, particularly children's health. Allergy testing can also be expensive. For example, one elderly gentleman, calling the National Eczema Society, said he had been charged £235 for a consultation. His urine had been tested. An "allergist" then gave him a long list of foods and substances he should avoid (which would have had a severe impact on his life) and
suggested a range of treatments which she could sell him. The bill, had he decided to buy the treatments, would have come to almost £600.

7.19. The press often hypes up stories relating to miracle cures and several stories have been observed in relation to eczema.

7.20. An article in "Best" magazine, headlined, "A MACHINE CURED MY ECZEMA", described how a young woman with ear eczema claimed to have been cured by being treated in a clinic with a machine, a process which involved sitting with her feet and hands on metal plates and with metal hammers held to her ear and kidneys.

7.21. "Chat" magazine under the headline, "PLEASE STOP THIS ITCHING", reported a woman's claim that her eczema was cured by use of a liquid containing honey, ginseng and royal jelly, and a cream which contained Royal jelly, ginseng and echinacea.

7.22. The News of the World described how a man with no medical training had scoured the Internet before developing a cream which contained "vitamins, lanolin and oil from the kernel of wheat". Under the headline, 'DADDY'S MIRACLE CREAM CURES TOT'S SKIN TORMENT" it said that cream was reported to relieve eczema, psoriasis and acne. The article carried a small boxed warning from a media doctor advising readers not to try the product until full safety checks had been carried out. Sensational media coverage of the cream prompted a flood of enquiries to the National Eczema Society. Analysis showed it to be no more than an emollient, but priced at £20 for a small tub.

Hair Loss

7.23. The enquiry also took oral evidence from a young woman suffering hair loss who, unable to obtain help from her GP or hairdresser, had attended a London trichological centre where she had been charged £10 for a "Tricho-Check". Thereafter, she had been invited to undergo twelve months treatment at a cost of £1,000 or risk becoming totally bald by the age of thirty. The centre said it guaranteed success but refused to put this in writing.

7.24. During one visit towards the end of the twelve months, the woman was approached by another member of staff who said she had been mis-diagnosed and persuaded her to sign up for a further year's treatment for an additional £1,000. There was no discernible improvement in her condition during, or after, either course of treatment.

7.25. The Group was also told of a chain of clinics in London and thirteen other cities throughout the UK. Enquiries by the British Association of Dermatologists established the clinic's charge for initial treatment for hair loss (for which there is no cure) to be £1,300. The weekly cost of continuing treatment was £45 per week or £2,340 per annum.

Clinics

7.26. The BBC1 consumer programme, Watchdog, sent two researchers masquerading as patients, into one of the clinics mentioned above. The skin of both women had been declared normal and healthy by a consultant dermatologist at St Thomas's Hospital. Seen by a "consultant" at the clinic, one researcher was told her skin condition was "urgent" and that she would need 60 treatments over three months at a cost of £960. The other was told she needed treatment for acne, also at a cost of £960. Analysis by an independent laboratory showed one cream prescribed by the consultant to be a water-based exfoliative cream, widely available for about £3 for 500 grams. The other was a water and alcohol astringent with a gelling agent mixed in, available from high street chemists for £3.09.

7.27. The enquiry was told of another clinic to which a teenage girl with acne paid £900 for two tiny pots simply labelled "Acne Cream 1" and "Acne Cream 2". After three months, and although there was no discernible improvement in her condition, she asked her father for £900 for a further three months supply. He reported the situation to the Skin Care Campaign. Pharmaceutical analysis of the creams suggested they contained no active ingredient at all and were unlikely to have any effect on the condition for which they had been recommended.

8.0. Role of the Press

8.1. The examples set out above represent only some of the many instances which were brought to the Group's attention in this enquiry. What is also clear is that an important role is played by local and national newspapers both in carrying advertisements for fraudulent products and by printing stories which sensationalise and amplify the claims made about some products.

8.2. Orthodox medicines undergo lengthy, expensive and rigorous testing procedures before they can be marketed. It is a major frustration that, in contrast, there are few constraints on the manufacture, supply and promotion of unorthodox treatments. This is particularly the case in the skin field where the dividing line between cosmetics - so-called "cosmeceuticals" - and pharmaceuticals is often deliberately blurred.

8.3. Furthermore, there is no restriction on the charges which such a clinic may make. They can charge what the market will bear.

8.4. The anomalies thus created are often innocuous. However serious problems can arise from public and journalistic appetite for ever more bizarre, exotic remedies. A "natural cure" backed up by the barest of anecdotal reports may often justify a double-page spread in a newspaper, leading to a wholly unjustified demand for a completely unregulated product.

8.5. The enquiry received as written evidence numerous examples of advertisements for clinics and treatments, including those for:

- a product which is marketed as a blend of resin, wax, essential oils and pollen, and which is claimed to be efficacious in the treatment of hypertension, artherosclerosis and coronary artery disease; for preventing and treating abscesses and ulcers; and for treating acne, allergies, herpes and other dermatological disorders;

- "the solution" to herpes and another device billed as a "revolutionary, hi-tech" solution to cold sores. Both treatments take advantage of the fact that they "deal" with recurring symptoms which heal by themselves, unaided, so it is difficult or impossible for the layman to establish whether they have any effect or not;

- an Irish firm which produces a cream for eczema, stipulating a 14 month programme for its use, at a total cost of £2,000. The cream is understood to be an emollient with eight herbal preparations added;

- Mahonia aquifolium (a.k.a Oregon Grape) - "therapeutic natural skin care with herbal extract" - a modest claim compared with the Daily Mail headline, "GRAPE CREAM THAT HEALED MY PSORIASIS".

8.6. In addition to the examples listed above, there are hundreds of companies producing topical applications which claim to be suitable for the treatment of skin diseases. Many are simple emollients with herbal additions. Although anecdotal evidence may support claims about the efficacy of these products, there is no clinical evidence to confirm these.

9.0. Enforcement

9.1. Government now accepts that some forms of "treatment" are not sufficiently regulated. Ministers have stated recently that "it is now generally accepted that the present regime for unlicensed herbal remedies does not offer enough protection

from unsafe remedies" - (Health Minister, Lord Hunt - Health Food Manufacturer's seminar, 2/11/99). The Group wishes to encourage consideration of how regulation could be further tightened and would be concerned if any delay in the current consideration of European regulation in this area was used as a reason to slow down progress towards better regulation in the UK.

9.2. Non-pharmaceutical companies vary in the ways in which they market their products. Some are responsible, following MCA guidelines regarding the claims they may make. Others, like those listed above, mislead people. Lack of clinical evidence makes it virtually impossible for people to judge whether a particular product may do harm or good.

9.3. Most advertisements in newspapers are entirely legal, being carefully worded so as not to infringe the code of practice of the Advertising Standards Authority (ASA). This means that under current law there is little redress and few advertisements are actually required to be withdrawn on grounds of code infringement. This is despite the fact that the ASA has shown a readiness to pursue claims that have been put to it.

9.4. Where claims are made, the ASA can only ask the advertiser to justify the claims (putting itself in the position of the consumer and what the consumer would infer from the advertisement). If the practitioner (who may be medically qualified) attempts to justify the claim, the ASA then needs to make a medical judgement as to whether this was right or wrong, which it is not well qualified to do.

9.5. The Group has been advised that changing the law (either by amending the Control of Misleading Advertisements Regulations 1988 or the Fair Trading Act 1973) would be pointless because the key to the problem is in the enforcement of existing regulations. Many claims are borderline and will not be pursued by Trading Standards Officers (TSOs) unless there is reasonable certainty of a successful prosecution. The Group accepts that TSOs are in an unenviable position both because they are too few in number and because it makes little sense to waste scarce resources by pursuing hopeless cases. Purveyors of fraudulent treatment make full use of the grey area of their operations for their success.

9.6. The Group therefore accepts the argument that there should be a medical regulator who could make a judgement in these cases. This regulator should operate within a clear and tightly drawn framework of what is allowable and what is not.

9.7. We welcome the MCA's yellow form reporting scheme for herbal remedies but believe that the MCA could use its powers more widely to prevent the marketing of suspicious products. It is difficult to believe that none of the products above merited prosecution.

10.0. Recommendations

10.1. Government should initiate an enquiry into the area of fraudulent medical practice. This should not be confined simply to skin since there are other types of medical condition which are also affected.

10.2. We would wish to see much greater intervention by those bodies which already have powers to investigate the claims of those who could be described as fraudulent practitioners. These bodies include the Medicines Control Agency and trading standards officers. We believe that the former probably has adequate powers which are perhaps insufficiently used. The latter requires such a large burden of proof to gain a prosecution that it is off-putting and this is the main reason why so few cases are brought before the courts. This area of law should be reviewed.

10.3. We agree with the Advertising Standards Authority's call for a medical regulator who would operate independently and transparently. This regulator would define terms such as "fully qualified", "experienced", "surgeon" or "consultant" as well enforce dubious claims of all sorts in any marketing literature or medium.

10.4. We believe that any "clinic" offering medical or related treatment for skin disease should be subject to the same strict regulatory framework as NHS establishments are.

10.5. Patients should be able to access a well-publicised help line to check on the veracity of claims made by such establishments or practitioners and to check for independent Government backed advice on dubious products. This could partly be facilitated through the use of a web site or some form of database of products or companies which are consistently the subject of complaint or which have undeclared ingredients.

10.6. There should be a compulsory “cooling-off period” in respect of contractual obligations to take up any treatments of this sort. This would involve there being an obligation on the
clinic to ensure that the individual who is contracting the treatment is required to wait up to ten days before any contract can become legally binding.

10.7. We would wish to see the widest possible dissemination of guidelines for choosing a safe complementary or non-orthodox treatment or practitioner. The Royal College of Nursing has already produced such a set of guidelines which are set out in Appendix Three.
We would add an additional question to the end of these guidelines which is:

10.8. Would you feel that you could trust the answer you have been given to any of the questions above and how would you set about making sure?

10.9. An education campaign should be funded to warn patients of the dangers of choosing a non-orthodox medical route without first consulting their GP, specialist or other suitably qualified individual.

10.10. The importance of listening to patients, devoting time to investigating symptoms and
experimenting with different treatments cannot be over-stressed. There is no doubt that the most effective way of avoiding fraudulent practice in dermatology is to remove the patient’s need to purchase the doubtful product or enter the clinic in the first place. This point should be forcefully impressed on GPs at the training stage (see previous report on training).

ENDS

Appendix One

Witnesses Providing Oral Evidence

27th April 1999

David Chandler - Psoriatic Arthropathy Alliance
Ms Terry Paddock - individual patient
Dr Elisabeth Higgins - Consultant dermatologist at King’s College Hospital

Dr Colin Holden - Consultant dermatologist at St Helier Hospital, Surrey and Honorary Secretary of the British Association of Dermatologists

8th June 1999

Ms Helen Sher - The Sher System
Ms Annie Cox - Dermatology specialist nurse at Royal Devon and Exeter Hospital
Dr Robin Graham-Brown - Consultant dermatologist at Leicester Royal Infirmary

Appendix Two

Special Advisers to the Enquiry

Professor Christopher Griffiths, Professor of Dermatology - University of Manchester (Chairman)
Professor Edzard Ernst, Professor of Complementary Medicine - University of Exeter
Peter Lapsley, Chief Executive - National Eczema Society; Chief Executive - Skin Care Campaign
Dr Tim Mitchell, Secretary - Primary Care Dermatology Society
Julie Moffat, Dermatology Specialist Nurse - Norfolk and Norwich Hospital
Michael Wadsworth, General Manager - The Vitiligo Society

Appendix Three

List of Written Evidence

Organisation	Evidence Number
The Psoriasis Association	01
British Association of Dermatologists	02
Johnson & Johnson	03
Sphere	04
Paul Rutter, Moss Research Practitioner	05
The University of Manchester: CRC Education & Child Research Group	6(a)
C.E.M Griffiths, MD, FRCP, Dept. of Medicine, Section of Dermatology	6(b)
Chris Barrett, M.Pharm., F. R. Pharm. S.	07

Organisation	Evidence Number
K.S.Gebhardt, St. George's Hospital	08
The Skin Care Campaign	09
Margaret L Price, MA, FRCP, The Brighton General Hospital	10
Dermal Laboratories Limited	11
European Commission, 'Unconventional Medicine' (1998)	12
The Pemphigus Vulgaris Network	13
Hansard, 14.12.98, Cols. 358 -9	14
National Eczema Society	15
Hansard, 22.12.98, Cols. 137-138	16
Article from The Daily Express, 26.2.1999	17
Article from The Independent, 26.2.1999	18
Article from The British Medical Journal, 1999;318:563-564 (27.Feb)	19
National Eczema Society: 'Steroids in Chinese Herbal Creams'	20
Malcolm Whitehead, MB, BS, FRCOG, King's College Hospital	21
Article from Geriatric Medicine, Vol. 29, No2, Feb 1999	22
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Advertisement 29
Article from Doctor & anonymous comments 30
Dr N.Cowley, MD, MRCP, MB, B.Ch, BAO, Surrey & Sussex Healthcare 31
Hansard, 13.4.99, Col. 106 32
Unsourced Article 33
Healthwatch Newsletter, April 1999, No33, Pages 2 & 5 34
Dr S.Handfield -Jones, West Suffolk Hospital 35
British Association of Dermatologists 36
Article from The Daily Telegraph, 19.1.1999 37
Article from British Journal of General Practice 1998; 48(437): 1873-1874 38
Dept. of Health Press Release on Herbal Medicines, 22.3.1999 39
Dr Elisabeth Higgins, King's College Hospital 40
Article and advertisement from The Sunday Times on 'Jan Marini' products 41/2
Articles from The Evening Standard 23.2.1999 & The Times 7.2.1998 43
Article from The Times, 12.3.1999 44
Article from The Independent, 23.3.1999 45
Hansard, 4.5.99, Col. 67w 46
House of Commons, Order Paper, 5.5.99, p.2598 47
Correspondence from a former clinic employee 48
Articles from Woman's Own, 23.11.1999, p. 20; Woman's Realm, 28.7.1998, p. 38; The Daily Telegraph, 18.11.1998; The Daily Mail, 21.7.1998 49
Medical records and testimony from a former clinic patient 50
Hansard, 26.3.99, Col. 426 51
Dept. of Health, Medicines Control Agency Letters 52
The Vitiligo Society (2) 53
Science & Technology Committee Report 54
Hansard, 19.7.99, Col. 416 55
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Vitiligo Society (3) 56
The Treatment of Eczema with Chinese Herbs: a systematic review of randomized clinical trials -
Armstrong NC & Ernst E; Br J Clin Pharmacol, 1998; 48:262-264 57
Numerous patient reports and nespaper cuttings were also received

Appendix FOUR

Royal College of Nursing Guidelines for Choosing a Safe Complementary or Non-orthodox Treatment or Practitioner

What are his/her qualifications and how long was the training?
Is he/she a member of a recognised, registered body with a code of practice?
Can you obtain the address and telephone number of this body so that you can check?
Is the therapy available on the NHS?
Can your GP delegate care to the practitioner?
Does he/she keep your GP informed in the same way that a hospital consultant would?
Is this the most suitable complementary medicine for your condition?
Are the records confidential?
What is the cost of treatment?
How many treatments will be needed?

Then ask yourself:
Did the practitioner answer your questions clearly and to your satisfaction?
Did the practitioner give you information to look through at your leisure?
Did the practitioner conduct him/herself in a professional manner?
Did the practitioner make excessive claims about the treatment?

It is best to avoid any practitioner who:
- claims to "cure" skin disease

- advises you to stop conventional treatment without consulting your GP
- makes you feel uncomfortable. You need a good relationship to ensure full benefit from any treatment.

Appendix Five

References

1-3. Zollman C & Vickers A, BMJ 1999; 319:693
4. Keane FM et al, BMJ 1999; 318:563-4
5. Clark CM et al, British Journal of General Practice, December 1998; 1873-4

All Party Parliamentary Group on Skin
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