

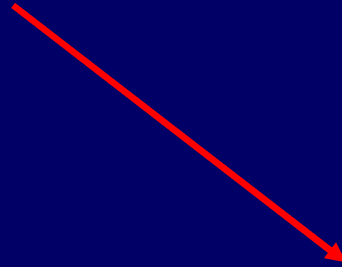
This is a data free RANT

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**On the subject of evidence-
based health care!**

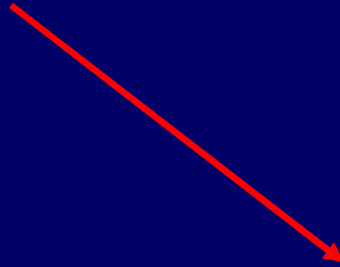
Positive

Positive

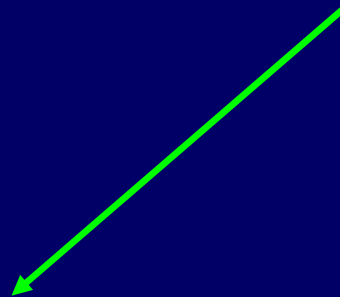


NEGATIVE

Positive



NEGATIVE



Positive

1. 'Positivity'

The Positive

Evidence based (bio)-medicine has been very successful in improving the management of some diseases

Examples

- Acute myocardial infarction and ‘clot-busters’
- HIV and anti-retroviral treatment
- Blindness and cataract removal
- Renal failure and renal transplantation

..... and many more

**The trouble is that this makes lots
of people (especially those who are
not health care professionals)
assume that (evidence-based)
biomedicine will lead to cures for
everything**

2) Negativity

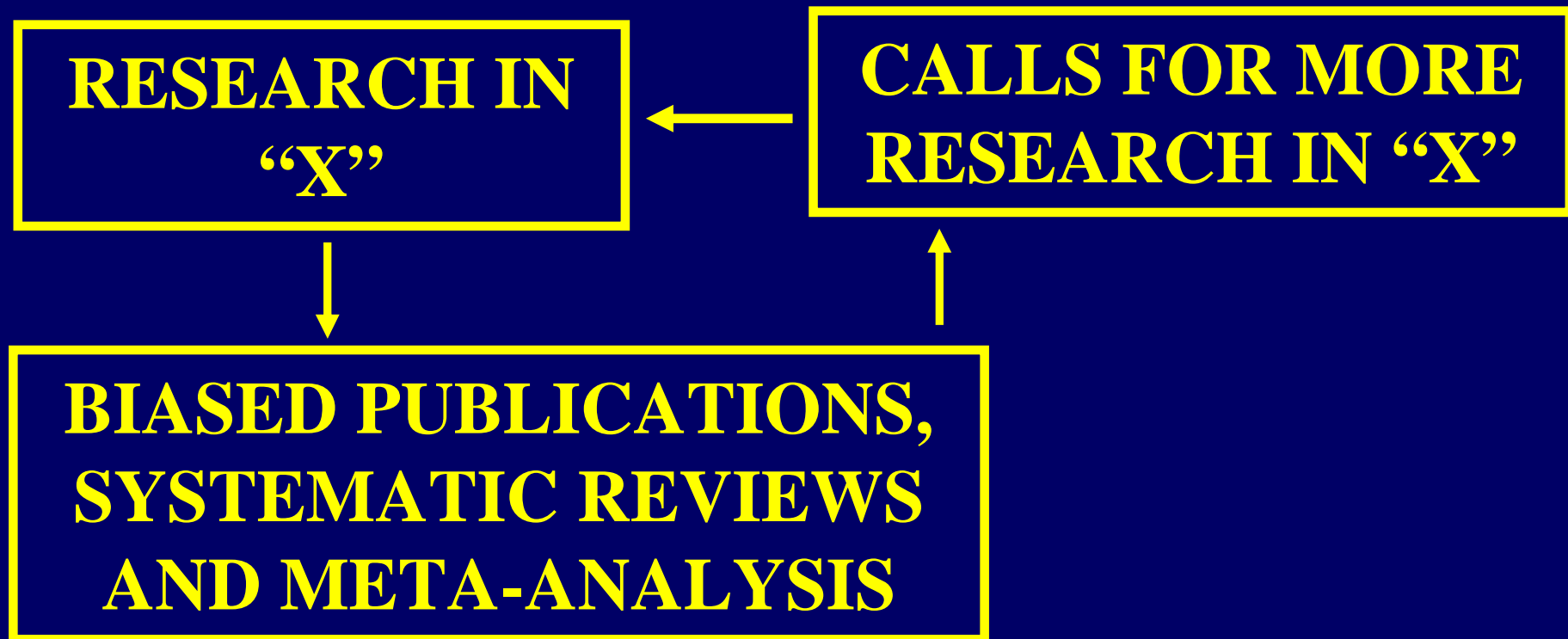
**The way we are going we will never
get the evidence we need to deal
with most chronic disease**

The problem

A major problem with health care research today is that it is controlled and carried out by people with a vested interest in the answers

The self-serving research cycle

VESTED INTERESTS

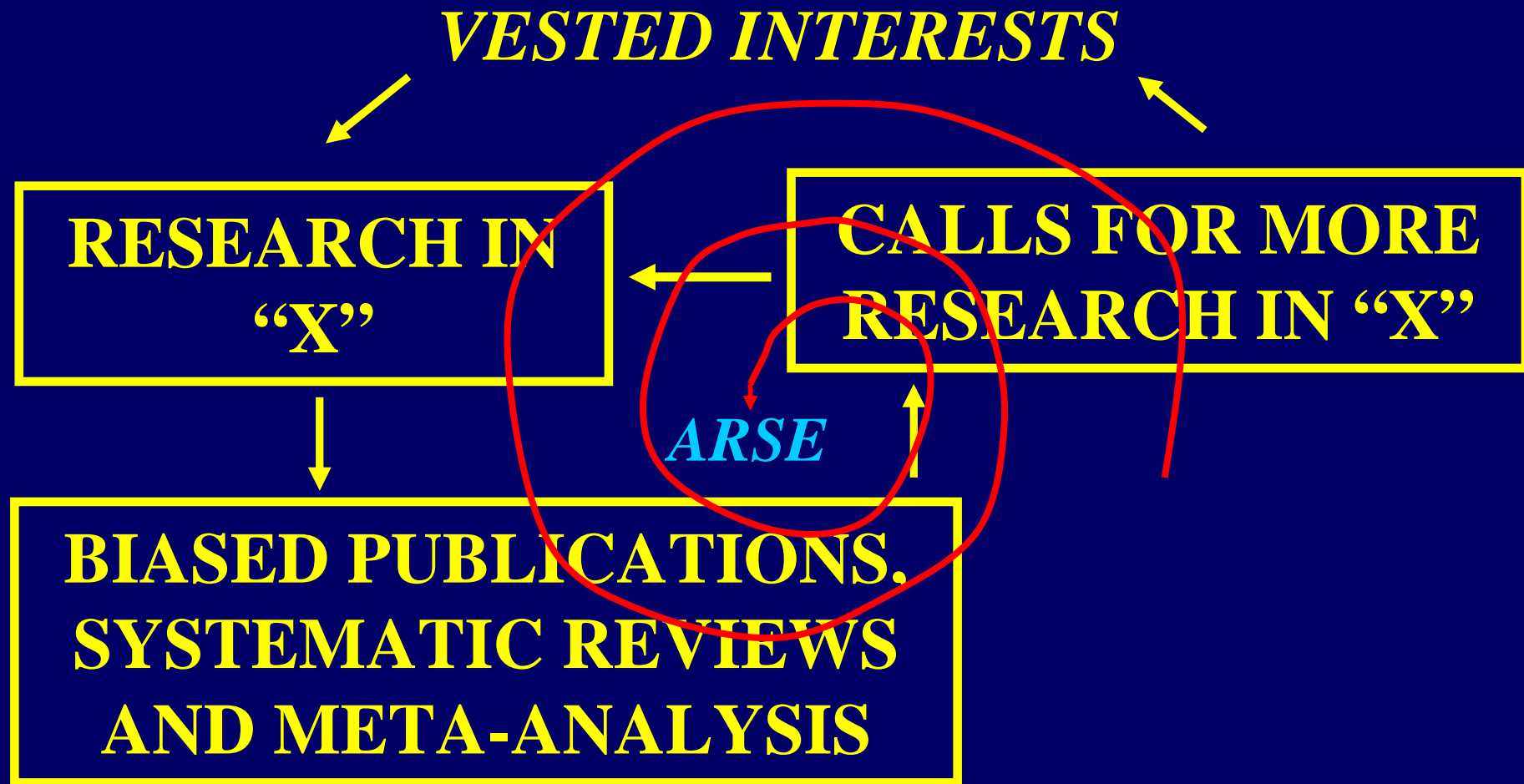


The self-serving research cycle

VESTED INTERESTS



The self-serving research cycle



The vested interests

1. Biomedicine
2. Pharmaceutical industry
3. Money
4. Glory

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In other words - our 'culture'

The current 'professional' research agenda

Is dominated by:

1. Biomedicine
2. The search for new drugs
3. 'Boys toys'

“The art of medicine, as reflected in the therapeutic potential of the clinical encounter has been marginalized in the wake of tremendous advances in the science and technology of medicine”

Kaptchuk 2008

So: What research do we need?

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I don't think anyone knows the answer to that,
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1. Less concern with acute disease, and more with chronic illness
2. **More focus on the psycho-social approach to health, instead of the biomedical one**

What research do we need?

I don't think anyone knows the answer to that, but let me suggest three approaches:

1. Less concern with acute disease, and more with chronic illness
2. More focus on the psycho-social approach to health, instead of the biomedical one
3. **A shift from technology-centred health care to person-centred health care**

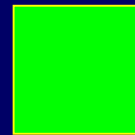
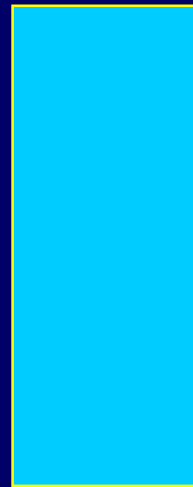
Some obvious examples of the 'wrong' research

1. We are developing drugs to treat obesity
2. Many people think that stem cells will be the answer to neurodegenerative disease
3. Many people are taking a drug for their depression, and hoping for a better one

**The example of
depression and the
effect of ‘placebos’**

RCT effects

Change



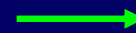
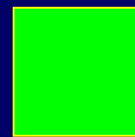
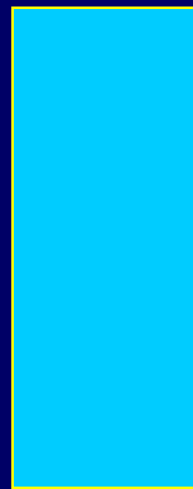
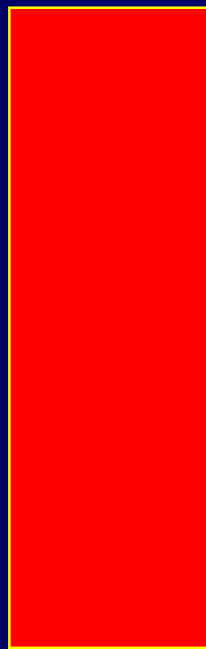
Net effect

Intervention

'Control'

RCT effects

Change



**'Medicine' is
only
concerned
with this bit**

Intervention

'Control'

Is the placebo effect ‘real’?

- The barmy right wing of the Cochrane religion thinks not (Hrobjartsson and Gotzche 2004)
- Most other commentators think there is a real effect – at least for pain and depression, if not for anything else (e.g. Kirsch 2008, Zhang 2008)
- **We need to distinguish placebo responses (‘context effects’) from placebos**

A historical perspective on placebo (E Ernst Clin Med 2008)

Distinguishes the context effect (non-specific effect) from the specific effects of different therapies through the ages

Effect **context effect** **net effect**

Effect **context effect** **net effect**

Blood letting

+ve



-ve

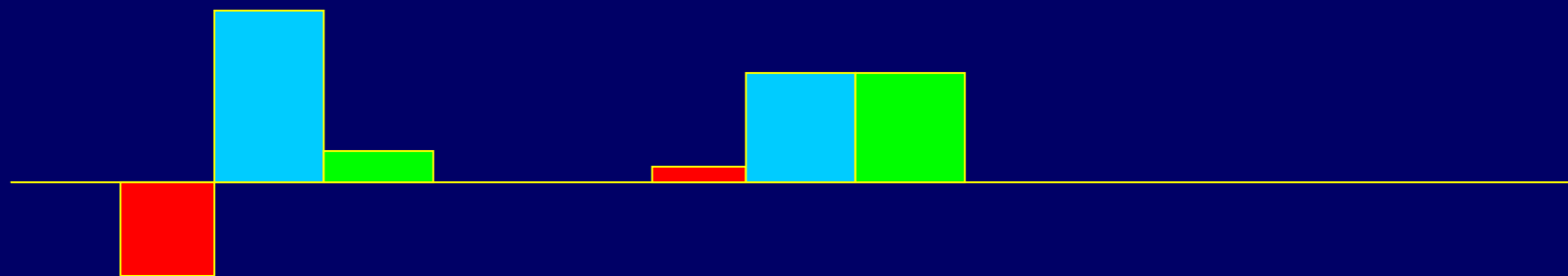
Effect context effect net effect

Blood letting

Homeopathy

+ve

-ve



Effect context effect net effect

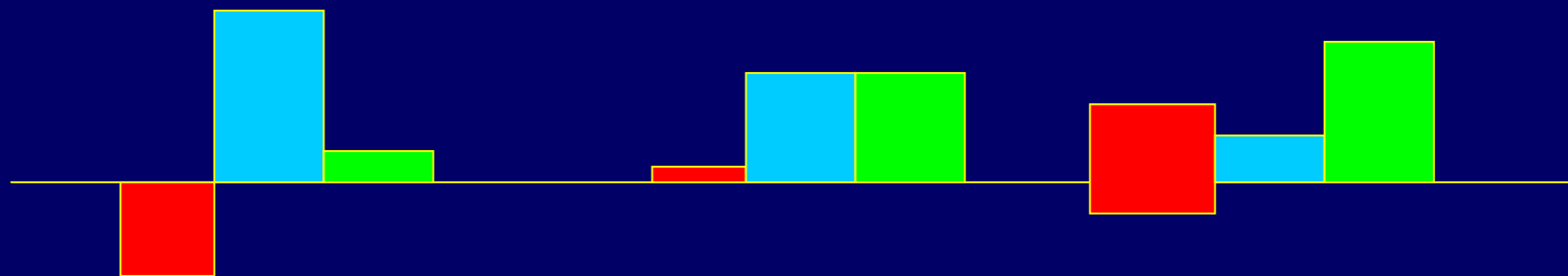
Blood letting

Homeopathy

Aspirin

+ve

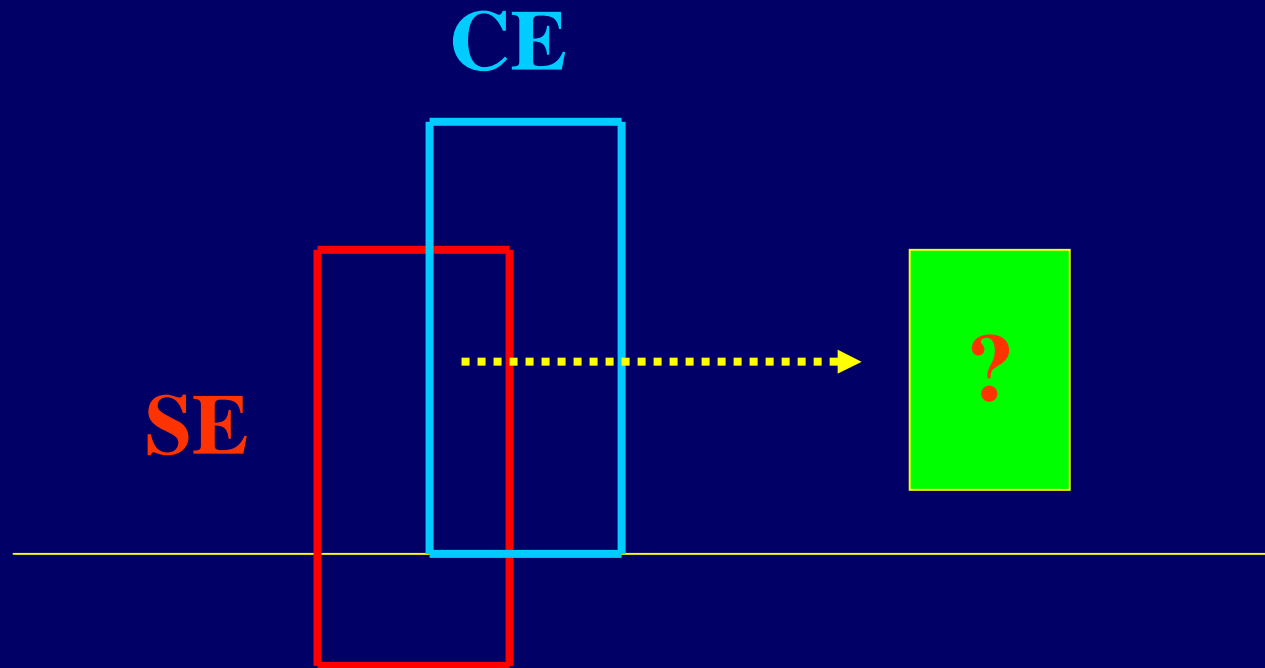
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BUT:

What happens if the context effect and the specific effect interact and are inseparable?

Specific effect and context effect



Assumption of the classic RCT

- That specific effects and context effects (characteristic effects and incidental effects) are divisible and additive

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- That specific effects and context effects (characteristic effects and incidental effects) are divisible and additive
- BUT: In many 'complex interventions' this is not the case (e.g. acupuncture and physiotherapy)

Paterson and Dieppe BMJ 2005

Interaction of specific effects and context effects

- Where making the diagnosis and offering an explanation for the symptoms is therapeutic
- Individualisation of therapy by adjusting what you do according to the response of the individual and their health beliefs

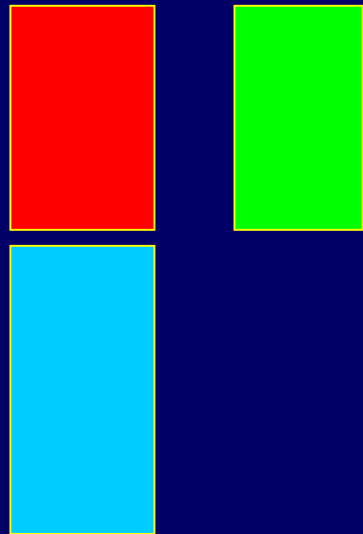
Interaction of specific effects and context effects

- i.e. what is generally done in clinical practice, especially by AHP and CAM practitioners

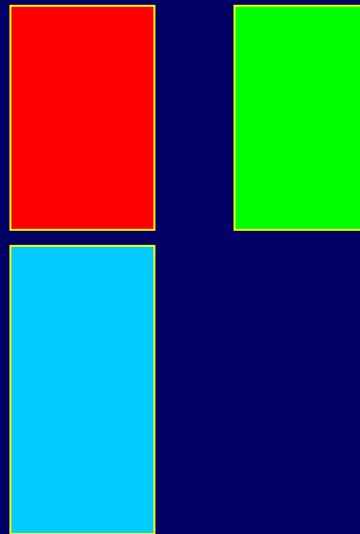
Interaction of specific effects and context effects

- i.e. what is generally done in clinical practice, especially by AHP and CAM practitioners
- Things that are regarded as a breach of intervention fidelity within the world of the classical RCT

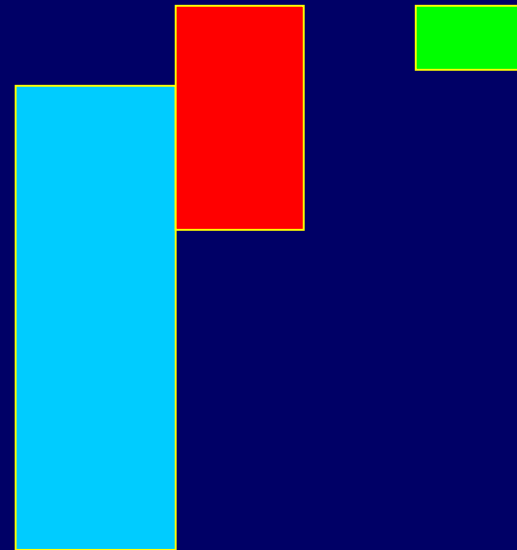
**Classical placebo-
controlled RCT
effect estimate**



**Classical placebo-
controlled RCT
effect estimate**



**Under-estimation
of effect if SE and
CE interact**



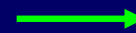
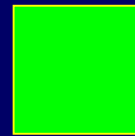
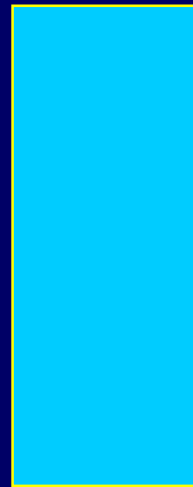
Components of the context effect (‘contextual healing’)

1. The ‘ritual’ – delivery of a symbolic intervention that has meaning for the individual (Kleinman)
2. The environment – ‘safety’ (Porges)
3. Personal interactions – a good relationship between patient and practitioner (Kaptchuk)

**Does complementary
medicine work because the
practitioners are
complimentary to patients?**

RCT effects

Change



**'Medicine' is
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concerned
with this bit**

Intervention

'Control'

Placebo controlled trials in osteoarthritis (Zhang et al, 2008)

- Most placebo controlled RCTs do not have a 'no intervention' comparison
- Those that do show clear evidence of a big placebo effect on pain (NB Hjarbotssen/Goetsche)
- The effect size of placebos is about 0.6, and greater for needles and creams than for pills
- The effect size of most 'interventions' is about 0.2

**So – why aren't we
researching and using
context effects?**

The current 'professional' research agenda

Is dominated by:

1. Biomedicine
2. The search for new drugs
3. 'Boys toys'

3) The Positive

Things ARE improving

Examples

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1. Involvement of patients and the public in developing the research agenda (COMPASS)

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1. Involvement of patients and the public in developing the research agenda (COMPASS)
2. Adoption of the bio-psychosocial model and increasing use of 'holistic health care'
3. Emphasis on spiritual dimensions of good health
4. Increasing money is available for research on good clinical questions, especially in the UK

CONCLUSION

We need to pay much more attention to ‘context effects’

(syn: incidental effects, contextual healing)

when exploring the potential value of what we do