Alternative allergy and the GMC

EDITOR,—There is scarcely an assertion in Richard Smith's editorial about the General Medical Council (GMC) with which I would not take issue.¹ I will restrict myself, however, to dealing with the main thrust of the editorial. Smith asserts that "the GMC was founded to protect the public against quacks." I disagree. It was founded to enable the public to identify qualified medical practitioners. It was given no powers in relation to those who are not so qualified, nor did the Medical Act 1858 prohibit the practice of medicine without registration. Many qualified members of the profession now practise, or refer patients to others who practise, treatments whose scientific validity is considered by some other doctors to be questionable. Acupuncture and homoeopathy are only two examples of many.

The GMC's powers over the registration—and hence the livelihoods—of doctors are already extensive. The exercise of these powers is triggered by complaints or referrals on specific matters, and the procedures are judicial. Parliament has not given the GMC the powers of an investigation bureau to assess the scientific validity of new treatments before allowing doctors to use them. That has never been seen as a constituent of self regulation, and I doubt whether any government would be willing to divert so many responsibilities already assigned to other existing bodies (for example, the Medical Research Council and the Committee on Safety of Medicines)—better qualified to carry them out—and concentrate them in the GMC alone under the sole control of the profession. Nor is it self evident that the profession could reasonably be expected to fund such a massive activity out of its own pocket.

Possibly Smith does not seek this, but only that the GMC should carry out such investigations in relation to particular treatments that it mistrusts. If this is the argument it neglects the fact that statutory bodies are given very specific powers. Once given those powers they must be seen to exercise them, and to exercise them impartially rather than idiosyncratically. It follows, I believe, that if the GMC was given responsibility in this area it would have to exercise it comprehensively, in an enormous number of areas of both conventional and unorthodox practice. It would not be allowed to pick and choose for long.

Smith's editorial talks about treatments that are risky. Few medical procedures carry no risk of any kind, and it seems to me that it would be impossible for one body to assume responsibility for measuring risks and assessing treatments throughout the whole of medical practice. Specifically, it is not the role of the GMC to decide medical controversies. The council does, however, bring a disciplinary case against a doctor who, having decided to practice a particular form of medicine or to carry out a particular procedure, does so in a way that can be shown to have been irresponsible, or unnecessarily hazardous to one or more patients, because the doctor has failed to exercise a proper standard of professional care; the council also brings a disciplinary case when a doctor makes outrageous and false claims regarding the efficacy of a particular form of treatment.

One final point. Smith suggests that doctors may be able to make swifter judgments than a lay jury on the weight and validity of scientific arguments.

Advice to authors

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As the BMA's own study of alternative therapy showed, life is not as simple as that.² The report concluded, among other things, that "many of the conditions which lead patients to consult practitioners of alternative medicine are ill defined, and either chronic on the one hand, or with a high rate of natural recovery on the other. These considerations make it difficult either to design a trial, or to interpret the findings."

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¹ Smith R. GMC in the dock again. *BMJ* 1993;306:82. (9 January.)
² BMA Board of Science and Education. *Alternative therapy*. London: BMA, 1986.

EDITOR,—Richard Smith is wrong.¹ The foundation of the General Medical Council (GMC) in 1858 (actually "the General Council of Medical Education and Registration") did not outlaw "quackery." The GMC was given the responsibility, among others, to see that doctors are properly qualified. But the GMC has not been given the power to set out which treatments are "scientifically validated" and therefore permissible and those that are not and therefore forbidden. This would be too akin to the power of the pope backed by the inquisition in the seventeenth century, or to Stalin's power backed by the KGB over soviet scientists in the twentieth century, to be acceptable.

As orthodox doctors we are dubious about alternative medicine and unqualified allopathists, but importing political correctness into a vocation that is not wholly scientific is loathsome.

Ostensibly the medical profession is self regulated. In truth, the profession in Britain is in thrall to a near monopoly employer (the NHS) in tandem with a regulatory quango (the GMC) and litigious "consumers" egged on by citizens' charters. It would not take much to turn fiercely independent professionals into demoralised, tame civil servants looking over their shoulders rather than at patients.

Unfortunately, by its campaigns of recent years the BMA has rendered itself virtually impotent in its defence of the profession against those who would shackle it.

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¹ Smith R. Treatment and the GMC. *BMJ* 1993;306:82. (9 January.)

EDITOR,—A B Kay attacks clinical ecology (environmental medicine to British doctors) and the neutralisation technique.¹ He does not refer to the evidence from the 1920s onwards that asthma, migraine, rhinitis, the irritable bowel syndrome, etc respond to the detection and

avoidance of triggers²; many conventional treatments have no better provenance. Ivory tower allergists discount reactions to food unless an IgE mechanism has been proved, but denying them or attributing them to hypochondriasis is a sign not of scientific superiority but of a head in the sand mentality.

Neutralisation is used by over 2000 doctors in the United States. It entails a testing session to find the end point (the first dilution of the extract that does not cause the weal to increase in the 10 minutes after intradermal injection) followed by prophylactic use of that dilution.³ Kay criticises this technique, citing imaginary dangers and ignoring risks of alternative treatments such as desensitisation and steroids. As an immunologist I dislike not understanding the mechanism (which logic suggests is immunological), but we use the technique regularly and it works. Until they improve and can manage without it, patients find that with neutralisation they stay well, living a less restricted lifestyle and eating a wider diet than without it.

The neutralisation technique has been validated by double blind randomised trials,⁴ including food trials showing its effectiveness in preventing symptoms.^{5,6} Studies that failed to show effects evaluated the provocation of symptoms by food extracts (not part of the standard technique⁷); that cited by Kay was also faulty in many respects and gave a wrong definition of the end point.

Maberly and I reported results in inpatients with asthma and are doing an outpatient double blind randomised trial of neutralisation.⁷ In a questionnaire follow up of mainly polysymptomatic patients (median duration nine years, 70% response) the number of severe and frequent symptoms had reduced from five to one per patient more than six months after inpatient investigation and 38% said that they were well or almost well. We plan to test the overall management strategy in a randomised referral trial (for which ethical approval has been granted), with pairs of patients identified by others randomised between this and any other treatment; if patients warrant admission, distance need not limit collaboration.

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EDITOR,—A B Kay's article¹ and Richard Smith's editorial² seek to use Keith Mumby's appearance before the professional conduct committee of the