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The Emperor's New Clothes:
Media Representations of Complementary
and Alternative Medicine: 1990-2005

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A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy by
prior publication

Department of Journalism
City University London
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VOLUME I: DISSERTATION

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Barbara Rowlands

Declaration

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Abstract

The purpose of this dissertation is to reflect on the author's published work in the field complementary and alternative medicine, specifically that produced between 1996 and 2005. It examines how the production of this work was influenced by the author's previous and concurrent experience as a medical journalist and the methodological challenges arising from sourcing complementary and alternative medicine and framing it for audiences of broadsheet newspapers and two books – *The Which? Guide to Complementary Medicine* and *Alternative Answers to Asthma & Allergies*. It explores how this work relates to scholarship in three key areas: the theory of sourcing, the theory of framing and the study of erroneous beliefs. The author demonstrates that a “perfect storm” – sociologically, culturally and economically – created a narrative that suited the new consumer-driven cult of the empowered individual, which in turn led to most sectors of the print media becoming impervious to any real investigation of the subject.

Chapter 1: Introduction

This dissertation is based on my work as a health journalist over 25 years and specifically my journalism in the field of complementary and alternative medicine. I wrote on this subject for specialist and consumer magazines and national newspapers and was the author of three health books aimed at a lay audience. In this reflective analysis, I will outline, explore and discuss how I conducted my journalism in this field, with specific reference to *The Which? Guide to Complementary Medicine* and *Alternative Answers to Asthma & Allergies* and to my articles, mainly for the *Daily Telegraph* and *The Express*, but I will refer to others, published elsewhere. So as not to repeat the full title of *The Which? Guide to Complementary Medicine*, I shall abbreviate it to *The Which? Guide*.

I shall use the initials CAM throughout to describe complementary and alternative medicine. It is not a description with which I agree, as describing this disparate group of therapies as “medicine” conveys a credibility most of them do not deserve. However, CAM is commonly used in academic literature, though some researchers use CTs (complementary therapies) or CATs (complementary and alternative therapies). Medicine is described by a variety of adjectives – Western, orthodox, conventional, mainstream, allopathic and biomedicine. To avoid a proliferation of terminology, I shall use the terms “mainstream” and “biomedicine”.

I will examine the reasons for the popularity of CAM, a popularity that was eagerly picked up by commissioning editors and book publishers. Through a powerful combination of personal anecdotes, increased consumerism and traditional news values, most sectors of the print media proved to be not only impervious to any real investigation (and therefore criticism) of CAM, but resistant to it. Some still are.

The dissertation explores how my published work relates to the academic literature in three key areas: the theory of sourcing, the theory of framing and the study of erroneous beliefs – why people believe things for which there is no evidence. Woven through this will be an examination of how science journalists conduct their work.

It is not my aim to examine whether or not CAM “works” or has potential risks, though this was the focus of my journalism. Instead, I shall look at the academic literature examining media coverage of CAM and investigate how journalists, including myself, operated in this field at a specific time in history.

Is there any neat definition that can scoop all these diverse therapies into a single rubric? The British Medical Association (BMA) defined CAM as “forms of treatment which are not widely used by orthodox health-care professions, and the skills of which are not

taught as part of the undergraduate curriculum of orthodox medical and paramedical health-care courses” (1993: 7-8). Eisenberg and colleagues define CAM as “medical interventions as not taught widely in US medical schools or generally available in US hospitals” (1993: 246).

Both definitions are problematic as some therapies are now offered in hospitals and taught in medical schools, as Coulter and Willis (2007) note. Moreover, defining something by what it is *not* is not particularly helpful at defining what it actually *is*.

Coulter and Willis argue that what links therapies as disparate as reflexology and chiropractic is what they term “vitalism” – a natural force that CAM practitioners believe exists within all living organisms, one “that is both different from, and greater than, physical and chemical forces” (216). This implies some sort of natural order, whereby the CAM practitioner merely facilitates the body’s own healing powers. This neatly scoops up all CAM modalities under one umbrella and contrasts them with mainstream medicine, where disease is explained (largely) in terms of biology.

A further definition is provided by Edzard Ernst. Ernst, now emeritus professor at the University of Exeter, was the UK’s only professor of complementary and alternative medicine and a prolific researcher into the efficacy of CAM and its associated risks. Ernst and colleagues define CAM as the “diagnosis, treatment and/or prevention which complements mainstream medicine by contributing to a common whole, satisfying a demand not met by orthodoxy, or diversifying the conceptual framework of medicine” (Ernst, Pittler and Wider, 1993: 2). These last two definitions I find the most useful.

Ernst noted in 2008 that there were around 42 million websites bombarding the public with information about CAM and numerous studies have shown how unreliable and misleading such information often is. Despite a plethora of information, 77% of patients feel “insufficiently informed about CAM” (Ernst, 2008). When I wrote *The Which? Guide*, CAM was booming – and yet the public was even less informed. It was my job, and those of other journalists in the field, to provide them with well-researched information.

Media research (in general) is categorised into three areas – production, content and audience (reception). I shall focus on the first two and address the constraints journalists faced when producing reports on CAM, the relationship between journalists and sources and journalists and their editors, and how CAM information was used in the media. How that content impacted on the beliefs, decisions and health choices of audiences would be a subject for further research.

Complementary medicine, as I wrote in *The Which? Guide*, “is a very broad church”

embracing what the BMA called the “discrete clinical disciplines” of acupuncture, homoeopathy, herbal medicine, osteopathy and chiropractic, but also including more esoteric therapies, such as crystal therapy, flower remedies, colour therapy, sound healing and colonic hydrotherapy. The 1986 BMA report, *Alternative Therapy*, listed 116 different kinds of complementary and alternative therapies. In the mid 1990s some had been subjected to extensive study; others had not. Some were found to be beneficial, but many were not and some were (and are) plain nonsense.

In the late twentieth century complementary medicine was becoming important commercially, medically and sociologically. There are a plethora of studies that demonstrate an increase in use between 1980 and 2000. In 1992, a Consumers’ Association survey of 1,000 readers of *Which?* magazine – a survey that led to the commissioning of the book – found that a quarter had visited a “non-conventional practitioner” in the previous year (The Consumers’ Association, 1992). Thomas *et al* (2001) found that over 31 million visits were made in 1998 in the UK to practitioners of eight established complementary therapies – acupuncture, chiropractic, homoeopathy, hypnotherapy, medical herbalism, osteopathy, reflexology and aromatherapy. Of these 200,000 reflexology visits and one million acupuncture visits were provided on the NHS. Eisenberg, in a widely-cited study, reported that 34% of adults in the United States had used at least one unconventional form of health care during the previous year and surveys showed that around a third of the European population used some type of complementary and alternative therapy (Eisenberg *et al*, 1993). The BMA’s 1993 report on complementary medicine, *Complementary Medicine: New Approaches to Good Practice*, which had a markedly different tone to its 1986 report, reported that non-conventional and traditional forms of medicine were “enjoying a renaissance throughout Europe” (BMA 1993: 9). Fisher (1994) found that in 1981, 6.4% of the Dutch population visited a therapist providing complementary or alternative medicine; by 1985 this figure had increased to 9.1% and by 1990 to 15.7%. The use of homeopathy in France rose from 16% of the population in 1982 to 29% in 1987 and 36% in 1992.

It is difficult to estimate how many people use CAM in the UK. Posadzki and colleagues (2013) note that, despite a large number of surveys, there are still no definitive data on the prevalence of CAM use in the UK. Most are flawed, Posadzki found, the response rate tends to be low and it is fair to assume that those who do respond are proponents of CAM. Consequently there is a “huge variability of data” on the prevalence of CAM (Posadzki, 2013: 128).

One of the most cited surveys was conducted by Thomas and her colleagues (2001).

They estimated that 10.6% of the adult population of England had visited at least one practitioner of the six most popular therapies – acupuncture, chiropractic, homoeopathy, hypnotherapy, medical herbalism and osteopathy – in the previous year. If reflexology, aromatherapy and over-the-counter herbal remedies were included, the figure rose to 28.3%. They estimated that in 1998, 22 million visits were made to practitioners of one of the six established therapies. A BBC survey on the use of CAM in 1999 (Ernst, 2000), based on 1,204 interviews, estimated that 20% of adults in the UK CAM used some form of CAM every year.

If the public demanded it, many doctors, particularly those in general practice, were happy to supply it, providing as it did a solution to those “heart sink” patients with chronic conditions often served poorly by mainstream medicine. *The National Survey of Access to Complementary Health Care via General Practice* (1995) by Thomas, in which doctors drawn from a random sample of 1,226 (one in eight) GP practices in England were surveyed, found that 39.5% of GP practices provided access to some form of complementary therapy for their NHS patients, 6.1% employed an independent complementary therapist, and an estimated 24.6% of practices provided NHS referrals for complementary therapies.

Ernst expressed concern about its increasing popularity within the medical profession and in an editorial in the *British Journal of General Practice* (1996) referred to a paper published in the *BMA News Review*, under the title “Doctors need evidence on complementary medicine”. In answer to the question, ‘Do you believe complementary therapies have a place in mainstream medicine?’ 65% of a sample of hospital doctors in the UK answered ‘yes’. He concluded that GPs faced a dilemma caused by the imbalance between complementary medicine’s popularity and the lack of reliable information on the subject.

But consumers appeared not concerned by this lack of evidence and faced with an increasing demand for this “product”, the Consumers’ Association decided to commission a book. I was approached in 1996 to write *The Which? Guide* by its publishers, Which? Books, a subsidiary of the Consumers’ Association. It was published in February 1997.

Its view – and mine – was that most therapies were not dangerous; for many people they simply didn’t work. The patient would have got better anyway. But complementary medicine did (and does) raise hopes and costs a considerable amount of money. Moreover, the industry is unregulated and anyone could (and still can) set him or herself up as a complementary therapist.

The Which? Guide was divided into two sections. Part 1 examined complementary medicine and the law, its use in the NHS, regulation, the scientific case for complementary medicine and the users and providers of complementary medicine. Part 2 comprised an A-Z of complementary therapies – 28 of them from acupuncture to yoga. The book concluded with glossary explaining specific terminology, a list of relevant addresses, a bibliography, index and reader's report form.

The structure was dictated by the publishers. My initial proposal suggested devoting separate chapters to the most popular therapies, such as aromatherapy and osteopathy, and a separate chapter on minor – and in some cases fringe – therapies. The publishers, however, wished to include as many therapies as possible. "The book will fail if people cannot find in it at least something on most of the therapies in current usage" I was told (personal communication, 29 April 1996).

I expressed my doubts about this as it would be giving equal credence to therapies that were plainly nonsense (for instance, the metamorphic technique, whose followers believe that our feet are in some way indicative of the time we spent in the womb) and would put them on an equal ranking with those which might give recipients some benefit, such as acupuncture and massage therapy. After a brief introduction, each therapy was rigidly broken down into eight sections: the theory behind it; what it might be good for; history; treatment; does it work? Can it do any harm? How to choose a practitioner and cost.

Research Challenges

In the mid 90s, the internet was rudimentary. Connection was by dial-up and there was no email. Search engines were basic and most websites were poor, with little useful information and inadequate search functions. Communication was mainly by post, telephone and fax.

I gathered information, like most other journalists, by phone. I rang every relevant organisation for leaflets and brochures, conducted around 60 interviews with scientific researchers, sceptics, legal experts, government officials, heads of complementary therapy organisations and people who had undergone complementary and alternative therapies – all of whom I relied on to feed me information, supply me with further contacts and alert me to developments in the field. I regularly visited the Wellcome Trust for its functioning internet link and library of peer-reviewed journals. Researchers sent me copies of their studies.

Which? Books required that every single statement of fact be backed up by evidence, which had to be referenced, mainly for its satisfaction, though many of the references were included in the book. I was commissioned to write 80,000 words. In the end, I wrote around 100,000 answering copious editorial queries that would be faxed through. Often I was asked to supply case histories, though it was not the style of the publishers to include them. These faxes have faded with time, but I enclose some of my responses to give a flavour of the rigour of the publishers [email to Emma Johnson, October, 1996. See appendix].

Investigating and writing about CAM was not like writing about the Consumers' Association's usual fare – cars, washing machines, credit cards or insurance deals. There were (and still are) two sides: on one side there were the believers and enthusiasts; on the other, the scientists and academics. At the time there was a paucity of credible evidence to indicate whether or not CAM benefited users.

There were sceptics, but they were hard to find. To research the chapters I conducted interviews with practitioners, the heads of the relevant complementary therapy organisations and scientists, academics and clinicians. Once I had delivered each chapter, the publishers would send it to an “expert” to review. Sometimes this would be the head of the relevant therapy organisation, someone with knowledge of (and sympathy with) the therapy. The result would be a fax filled with queries that I had to refute. One telling phrase in my comments was:

“I feel strongly that the Consumers Association should not be seen to give the same weight to the opinion of a colonic hydrotherapist than to a consultant in gastroenterology.” (personal communication to Which? Books)

Early in my research, I contacted Edzard Ernst. I visited his department on 18 April 1996 and interviewed Ernst and his colleagues. After my visit, Dr Adrian White, a research fellow at the university, wrote to me on 22 April 1996.

“We appear to be the only group making a critical appraisal of the subject of complementary medicine ... and I want to try and prevent your being lured away from proper objectivity by people who are totally enthusiastic, and possibly less objective.” (personal communication, 22 April 1996)

At the time of writing, research into complementary medicine was ongoing. As Ernst noted:

“As long as a remedy has not been tested, it cannot be labelled as either effective or ineffective. Furthermore there are areas within complementary medicine which have

demonstrated potential usefulness through randomised controlled trials.” (Ernst, 1995: 244)

This particular paper gave some of the main arguments from both “sides” and provided me with a wealth of primary and secondary sources. I would track down a relevant paper and interview the lead researcher, who in turn would give me more sources and contacts.

After the publication of *The Which? Guide*, I was approached to contribute to a column, ‘Does it Work?’ for the *Daily Telegraph*, and to write a series – ‘Exploring Alternatives’ – for *The Express*. I was commissioned by a number of national newspapers and consumer magazines to write on CAM and by Marshall Publishing to write *Alternative Answers to Asthma & Allergies*, which was published in 1999. For this journalism I estimate I conducted a further 100 interviews, as well as examining secondary sources.

This surge in the use of CAM in the late twentieth century and subsequent widespread coverage in the print media was the result of a “perfect storm” of cultural, sociological and political changes that resulted in it being framed in a specific way. It was transformed from “fringe” therapies, seen to be used by cranks and hippies, to respectable modalities used by almost a third of the population in the UK and recommended by GPs and available under the NHS.

CAM, as Coward points out (1989: 42-67), was at the forefront of new ideas about the body and the individual. Most users of CAM were women and it empowered them to wrest some control of their health from what many regarded as paternalistic and patronising interventions by conventional medicine, particularly in areas such as contraception, abortion and childbirth (Fitzpatrick, 2001: 138). This played well into the “soft” news agenda, under which definition women’s consumer magazines and health pages fell (“hard” health news is given a higher billing on home news pages). It is no surprise that the largest weekly national newspaper health section is still in the *Daily Mail*, which has a large female readership.

The rise in the use of CAM led to an increase in research into its efficacy and the birth of peer-reviewed journals devoted to the subject. The Guild of Health Writers, of which I was to become deputy chair, was founded in 1994. It was established to complement the Medical Journalists’ Association (MJA) and its members wrote “on every aspect of health and wellbeing, from innovative medical science to complementary therapies and lifestyle issues” (Guild of Health Writers website).

CAM was fresh and promised much. Its narrative fitted neatly into the new consumer-driven cult of the individual and the turning away from mechanistic medical

interventions. There were more well-meaning believers than charlatans and the evidence that any of it actually worked was equivocal, but editors wanted journalists to write about it and answer two questions: Does it work? Is it safe? It was not an option to dismiss it, as Dr Jonathan Miller did in an interview in *Vogue* in 1978, as “jabbering, obscurantist, mysticism ... most of fringe medicine today is simply survival of techniques used in antiquity because there was nothing better...To go back to them now it like striking flints to light the gas fire”.

But to cover it was like entering a journalistic minefield. There were few reliable sources as journalists soon discovered, and those we did find were low in the hierarchy of medically-qualified sources we traditionally used, who often knew little about CAM and/or dismissed it out of hand. Therapies often had several organisations, each jockeying with each other for publicity, each of which told different stories. The boards of the new peer-reviewed journals often had links with CAM.

Media representations of CAM seems quite a narrow subject, but when exploring the literature, revisiting my own journalism and in discussions with my supervisors, it became clear that it is a sprawling and complex area embracing the legacy of the counterculture, the rise of individual consumerism, attitudes to science and technology, medicalisation of behaviour, feminism, religious and spiritual revival, attitudes to the body, and an uncritical acceptance of modalities and their founding “masters” that has parallels with cults.

Complementary and alternative medicine was not just a collection of physical therapies and techniques: they were to become a form of cultural practice bound up with new forms of bodily understanding and conceptions of selfhood, an intertwining of health care, pleasure, solace and consumption (Barcan, 2011). I am aware of all these things – and more – but the scope of this dissertation prevents me from exploring them fully.

Its purpose is to examine how I navigated this minefield, what sources I used and how and why CAM was framed in a specific way at a particularly time.

Chapter 2: CAM: The Media's Darling

When I revisited my journalism on this subject – the first time in some years – I was concerned by what, at first, appeared to be a lack of rigour. There have been a number of books published recently (Singh and Ernst, 2008; Barker Bausell, 2007; Shapiro, 2008; Goldacre, 2009; Offit, 2013) that have questioned why, as a nation, we spend millions on therapies that are mostly unproven and occasionally dangerous.

What I had forgotten was the specific time during which I generated this work – the mid 1990s. While evidence was growing that CAM was not completely harmless (Ernst and Hentschel, 1995; Ernst, 1995), there was a small body of evidence that some therapies might be beneficial. Some, such as iridology, were easy to dismiss:

“There is no scientific evidence to back up claims made by iridologists and ophthalmologists do not recognise iridology as having any place in medicine.” (*The Which? Guide to Complementary Medicine*: 172)

Nor was there any evidence Ayurveda, reflexology or the less well-known therapies, such as kinesiology, had a beneficial effect on patients, despite positive anecdotal reports. But other therapies, such as osteopathy, herbalism and acupuncture, had some studies that supported some of the claims of practitioners. At the time of writing both books there were a number of trials in Western peer-reviewed journals that demonstrated that people with osteoarthritis of the knee, asthma and nausea gained relief from acupuncture (ibid: 79). There were a number of studies in peer-reviewed journals that attested to the efficacy of some supplements about which I was writing.

More significant, however, was a powerful combination of cultural, political and sociological changes and movements that combined to make CAM not just popular, but fashionable. It had moved from being labelled as “fringe medicine” (the title of one of the first books on the subject by journalist Brian Inglis) to “alternative” (*Alternative Therapy* was the title of the BMA's 1986 report) to “complementary medicine” (the title of the BMA's 1993 report). It was flourishing and seeming evidence of a “flight from science” declared in BMJ's opening editorial in January 1980. It is interesting to note that the titles of the recently-published books re-examining CAM have included the word “alternative”.

In this chapter I shall explore the reason for CAM's popularity and how this provided a fertile seedbed for the rapid growth of journalism in this field, particularly across national newspapers and magazines.

Fulder (1996) remarks on the “sudden growth in media reportage” on CAM, and this reached a peak in the 1990s. The *Independent on Sunday's Style* supplement ran a weekly series in 1996, under the title ‘The A-Z of Alternative Medicine’. At the same time, *The Sunday Times* magazine published a lavishly-illustrated four-part supplement on the A-Z of Chinese medicine. The introduction to the series included an interview with a Professor Kanwen Ma, qualified in both Chinese and Western medicine, and an A3 gatefold of the meridian lines¹. It is hard imagine such supplements being published today.

The *Daily Telegraph* ran its ‘Does it Work?’ column, to which I was a regular contributor, and *The Express* its ‘Exploring Alternatives’ series – again I was a regular contributor. Magazines had their resident CAM columnists and health coverage focusing on conventional medicine often included potential CAM treatments. Publishers, too, were not slow in recognising the popularity of CAM. Both Hamlyn and Dorling Kindersley published weighty illustrated encyclopedias of complementary medicine in 1996 and 1997 respectively.

So how do we account for this seemingly dramatic change in public attitude? What happened which made people turn away from mainstream medicine that had served them so well and which, since 1946, had been free?

Medicine in the Dock

Part of the answer lies in what Michael Fitzpatrick called a “crisis of medical confidence” during the 1990s. Fewer new drugs were coming on to the market, and the public was becoming concerned with side-effects (Fitzpatrick, 2001). The most traumatic example was from the drug thalidomide, a sedative originally developed for anxiety, but later prescribed to pregnant women for nausea. In addition, millions of women taking the contraceptive pill, introduced in 1961, were shown, in a series of research papers in the late 1970s, to be at risk of blood clots, heart attacks, strokes, depression, weight gain and loss of libido. Mortality rates from cancer remained unchanged during the 1970s, with no real improvements in breast or bowel cancer or rates of lung cancer in men (Cancer Research UK).

There was a vigorous public debate around the medicalisation of childbirth. Home births had fallen from 42.4% in 1946 to 12.4% in 1970, and forceps deliveries, Caesarians and induction of labour increased (Karpf, 1988). Patients languished on long hospital waiting lists. Despite the introduction of the internal market in 1990, a year later,

¹ Meridians – an invisible pathway of channels through which flows life energy or *qi*

120,000 people had been waiting at least a year and 50,000 people at least two years for hospital procedures (Propper *et al*, 2000). Medicine had become more technological in its approach and cure detached from care as patients underwent scans and tests and were prescribed technical and pharmaceutical interventions with the physician taking little or no account of the patient's subjective experience of the illness (Sharma, 1992).

Then there were a series of medical scandals. The inquiry investigating the high mortality rate of babies undergoing heart surgery at the Bristol Royal Infirmary published its report in May 1998. Between 30 and 35 babies died between 1990 and 1995, the inquiry found, while over the whole decade up to 170 might have been saved had they been operated on elsewhere. This led to an inquiry by the General Medical Council and criticism in the media of medical paternalism, arrogance and lack of regulation (Seale, 2002). Between 1988 and 1995 organs and body parts from around 850 children were discovered in 2,000 clinical pots at Alder Hey Children's Hospital in Liverpool. After the story broke, hospitals were besieged by families demanding the restoration of missing body parts of their loved ones, which Seale argues was a direct challenge to medical power by consumers (2002: 163).

Fulder writes that patients turned to CAM for relief from "failed treatments, lack of understanding, lack of heart, obsessive technicality and side-effects" (1996: 13). This is a reductionist view. There was little doubt that many doctors found it difficult to be continually sensitive to the needs, hopes and fears of every patient, as Thurstan Brewin, chairman of the small medical charity and sceptic group HealthWatch, notes:

"Mainstream medicine...cannot easily find time to cope with the increasing demand, not just for the essential information and the moral support that have always been such a vital part of the doctor's job, but for far more lengthy and comforting and counselling. Perhaps fringe medicine can supply this need." (Brewin, 1994: 244)

Yet despite a growing disillusionment with modern medicine, there was little evidence to suggest a wholesale rejection of it. Rather, the public was taking a pragmatic "pick and mix" approach to their health. Reviewing the available evidence on the use of CAM, Zollman and Vickers (1999) found that people who consulted CAM practitioners tended to do so for longstanding conditions for which conventional medicine had not provided a satisfactory solution. People turned to CAM to alleviate the symptoms of chronic conditions, such as arthritis, skin conditions and musculoskeletal disorders (Vincent and Furnham, 1999).

In the US, Astin (1998) started his research with the hypothesis (among other hypotheses) that people sought out alternative medicine because they were dissatisfied

with conventional medicine. His survey of 1,035 randomly-selected individuals (the response rate was 69%) found that only 4.4% were reliant primarily on alternative health care, suggesting that most people use CAM in conjunction with conventional medicine.

The Health-Conscious Consumer Hero

Paul Stoneman and colleagues (2013) note that studies looking at what type of people use CAM reveal empirical regularities: they tend to be early to middle-aged, female, well educated, higher than average earners and suffer from poorer self-reported health. Vincent and Furnham (1999) found that users also tend to be of higher than average social class.

Astin, even though his sample was small (714), found that people were likely to use alternative forms of healthcare not because they were dissatisfied with conventional medicine, but because “they found healthcare alternatives to be more congruent with their own values, beliefs, and philosophical orientations towards health and life.” (Astin, 1998: 1548)

Such people, he said, had a “philosophical orientation” toward health that could be described as holistic – in other words they believed in the importance of the link between body, mind, and spirit. In sociological terms, Astin said, they could be classified as “cultural creatives”. He postulated that a significant number of people who report poor health might be “somatizers” – in other words, their aches and pains are psychosomatic and have no pathophysiological explanation. Such people prefer to maintain control over their health care decisions (ibid: 1552).

But the battalions of “worried well” and “cultural creatives” only partly account the increased use of CAM. Vincent and Furnham (1999) found there was little to support the view that people who used CAM were gullible or naïve, but there was evidence to show that they were more health conscious than non-users, had less faith in mainstream medicine and believed more strongly that people could influence their own state of health.

The swelling ranks were also motivated by the feeling that feeling “all right” was not enough – that the goal was “optimum health” and “well-being” (interestingly, the hyphen has now been dropped, embedded as it is in the national health agenda). “Total” health was not just the absence of disease, but something people could control, something, as Coward writes “locked within us, waiting to be released” (Coward, 1989: 42). The conclusion of this “logic” is that if total health was trapped within the body (and many of

the therapies are based on the concept of freeing “blockages”) then the individual had the power to release it and achieve positive health.

Woven into all this, was the rise of what Seale (2002) calls the “consumer-hero”. The media began to present a much more “narcissistic, pleasure-seeking” image of the health consumer, able to choose from a range of health-giving “natural” products and considerably removed from the image of the docile medical consumer of the 1950s. In this scenario, Seale argues, the doctor-hero is very much in the background. The “technological rescue motif”, which had served the media so well for decades, appeared outmoded.

Writing over a decade earlier, Karpf says that the educational and economic boom had together produced a mass of people working in the arts, social sciences and service sector, disengaged from the means of production, as never before, a “cohort of articulate, critical people with no commitment to commerce or industry.” (1988: 58). She argues that this rise in consumerism raised important questions about medical dominance and put the patients’ experience “squarely on the media agenda”. She recognised that the media’s attitude towards complementary and alternative therapy was becoming more sympathetic and mentions the BBC’s peak-time broadcast of a six-part “decidedly unhostile” series on the Bristol Cancer Centre, which treats people with cancer with diet, meditation, breathing exercises and relaxation. When the BMA published its damning report *Alternative Therapy* (1986), the BBC science correspondent dismissed it as “biased” (Karpf: 177).

CAM was in keeping with the anti-science, consumer-driven individualistic view of health, but Karpf argues the media often resisted this new agenda. Journalists, like myself, who were writing on the subject, continually endeavoured to validate the claims of complementary practitioners by looking at the science (if there was any) and interviewing our sources of first choice – doctors and research scientists. Karpf notes that the “false hopes” argument “weighed heavily” on producers’ minds when airing programmes on holistic therapies, as did the 1939 Cancer Act that stipulates that no claim for a cure for cancer can be made in the media. When the Bristol Cancer Centre series, originally titled *A Gentle Way with Cancer*, was trailed in the *Radio Times*, it had a question mark at the end.

Women and CAM

Feminism in the 1970s redefined women’s relationship with their health, with the delivery of their healthcare and with medical ideology. Feminists identified the politics of sickness and condemned the difference in status between doctors (usually male) and

patients (often female). They demanded the right not only to know about procedures that affected their bodies, but the right to decide about them too. In 1971, the Boston Women's Collective published *Our Bodies, Ourselves* (Karpf: 59).

Doel and Segrott (2003), in their examination of UK health and lifestyle magazines, maintain that the very act of deciding to use CAM is an act of resistance to dominant practices and a form of self-empowerment – its weapons a plethora of products, practitioners, self-help books and websites. In their exploration of women's magazines, they note:

“The call for readers to ‘find out more’ is presented as the gift of taking responsibility, becoming informed, and achieving self-empowerment...In many ways, health – and especially ‘holistic’ health – is treated as a gateway that leads towards dis-alienation, new ways of living, and solutions to the problems that women experience in everyday life.” (142)

I would argue that this self-empowerment has become a tyranny, particularly for women, binding them in a never-ending quest for “total” health that they may never achieve. And for women it was, and is, a quest. Doel and Segrott note that more women than men use the “softer” therapies of touch, such as aromatherapy, therapeutic touch and reflexology; men go for more macho therapies, such as acupuncture or osteopathy. Like their attitude to medicine, men want a quick fix.

The rise of CAM, and its narcissistic offspring, wellbeing, adds a layer of guilt to illness, as Coward notes. Disease, rather than being caused by a random germ or genetic inheritance, is now the fault of the sick person whose responsibility it is (or was) to keep well. One of the fundamental diktats of CAM is that we do not have to live with illness – our lifestyle, attitudes and personalities invite it in – and, after the publication of the contentious Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) in 2013, there are more disorders and syndromes than ever to which we can succumb. The media, in the look-after-yourself national newspaper health pages and drive for positive stories, play into this agenda and largely focus on prevention.

Dworkin (2001) believes that CAM benefitted from the decline not just in mainstream medicine, but in organised religion. In the past, people found relief from their “heavy joyless lives” by turning to doctors and/or clergymen. Modern medicine, Dworkin argues, turned doctors into “skilled tradesmen” working in a hyper-rational environment with little time to devote to “a small crisis of the spirit”.

“Patients are fleeing the medical profession because doctors concentrate on rational knowledge at the expense of life's mysteries. Organized religion concentrates

exclusively on the unknown, and therefore seems to know nothing. In alternative medicine, people have discovered a compromise. Considering that the two great misfortunes of life are illness and gloom, any discipline that promises to ward off both in a single stroke will not go away soon.” (18)

CAM so “artfully conspired” to make patients believe that their illness had some kind of spiritual significance that once they absorbed the fiction, they were “enslaved” by it (ibid: 10). In the 1990s, despite the fact that there was little or no evidence that most complementary therapies actually “worked”, many users *believed* they did, as Posadzki and his colleagues in their review of CAM surveys note in their conclusion. “The average perceived effectiveness of CAM was substantial” (Posadzki, 2013: 128).

The fact that a therapy, such as acupuncture, was “tried, trusted and...hugely popular” (*Health Which?* June 1996) was just too powerful, even for an organisation committed to rigorously scrutinising products and services and enabling consumers to make informed decisions. In a standfirst² to this feature on acupuncture, the Consumers’ Association asked:

“Thousands swear by it. Yet cynics say there’s no proof that it works. Does that matter?”

It did then and certainly does now.

² Short paragraph underneath a headline that introduces a feature

Chapter 3: Literature Review: Media Coverage of CAM

The media play an increasingly significant role in disseminating knowledge about illness, treatments and healthcare. As a clinical review in the *BMJ* noted, media coverage of CAM had increased “dramatically” in the previous 20 years (Zollman and Vickers, 1999) and there is a substantial body of research to show that users of CAM are not only self-empowered and well-informed, but more likely to use information sources outside mainstream medical practitioners (Fulder, 1996; Sharma, 1992; Kelner and Wellman, 1997).

Media coverage has increased to meet demand and news stories and features now form a major source of information and can persuade consumers whether or not to use it (Grilli R *et al*, 2000). Kelner and Wellman write of “smart” consumers “up-to-date on the latest ‘infomessage’ from the media” (1997: 211). This “message” is important as some CAM products and therapies can be dangerous, not just in the toxicity of products, such as Chinese herbal medicine, but also in the interaction with conventional medication and in delaying patients’ access to mainstream medicine (Ernst, 2000).

In this respect, Schwitzer argues (2005), journalists have a special responsibility in covering health and medical news and that their “beat” is unlike any other, such as politics or business. They must investigate and report on the possible links between researchers and private companies, patient advocacy groups and their sponsors, celebrities, and non-profit health and professional organisations and their sponsors.

“To fail to do so may mean that journalists become unwitting mouthpieces for incomplete, biased, and imbalanced news and information.” (Schwitzer: e0576)

The same applies to reporting CAM. CAM is a newcomer in the field of biomedical research and reporting how media cover this research – and CAM itself – is limited. Most researchers (mainly drawn from UK, Canada, Australia and New Zealand) examine the print media, mainly newspapers, but four were found that examined coverage in lifestyle and women’s consumer magazines. The disparity of research examining CAM coverage reflects a more generic bias in journalism research towards news journalism, which I shall explore in a later chapter.

Researchers who cover media representations of CAM are drawn from many academic fields. Weeks and her colleagues (Weeks and Strudsholm, 2008) acknowledge the increasing relevance of scholarship in this field, which covers the disciplines of medicine, sociology, media studies, complementary medicine, cultural studies, pharmacy and others.

Most of this research focuses on the coverage of supplements and diet and nutrition, arguably on the cusp between CAM and mainstream medicine. Few examine how therapies such as acupuncture, chiropractic and Western and Chinese herbal medicine, (where most of the adverse events occur) are dealt with in the media. Researchers often focus on the use of CAM in the treatment of cancer, but not on its use in chronic conditions, for which it is more suited. Mercurio and Eliot (2011) suggest this may reflect an increasing interest in CAM by the medical community, and its widespread use by cancer patients. They argue that continually presenting CAM as a potential cure for cancer, the media may reinforce biomedical mistrust of the CAM community. It might also reflect concerns among biomedical researchers that CAM is being promoted in the media for life-threatening conditions.

What research there is shows that media coverage tends to be “over-enthusiastic, inadequate, incomplete and insufficient to make an informed choice” (Milazzo and Ernst, 2006: 885). Accuracy was found to be the highest in hard news reports in national newspapers and lowest in television current affairs programmes (Bonevski *et al*, 2008).

And scholars have criticised the media for providing a “too rosy” picture of CAM, downplaying adverse reactions (Bubela, Caulfield and Boon, 2006: 3). Consumers, who often self-administer CAM, “are not being provided with information to make informed choices about treatment alternatives”. (Bubela *et al*, 2007: 363)

Ernst and Weihmayr (2000), comparing the frequency and tone of reporting on medical topics in eight daily newspapers in the UK and Germany found that British newspapers reported on medical topics twice as often as German newspapers and were more critical than those in German newspapers, but the reverse was true of media coverage of CAM. They isolated four articles in the German newspapers and 26 in the UK newspapers about CAM and found that while the UK articles were unanimously positive, three out of the four German articles were critical.

Bubela and colleagues (2008) compared newspaper coverage between 1995 and 2005 in the UK, US, Canada, Australia and New Zealand of clinical trials for herbal remedies with the coverage of clinical trials for drugs used to treat the same conditions. They conclude that the media continue to provide insufficient information to the public – mainly through under-reporting and/or omission – about the risks, funding and conflicts of interests of both herbal remedies and pharmaceuticals.

The academic research thus tends to suggest that some sections of the media should have had a more critical attitude to reporting CAM. Yet, while media coverage raises concerns about accuracy, balance and the quality of information, it can also inform

readers about a range of treatment options not always discussed by conventional healthcare providers – therapies that might support conventional treatment and address a patient’s psychosocial needs (Weeks *et al*, 2007).

However, there is also the misunderstanding among scholars about how health journalists see their role. They do not seek to provide the public with all the relevant information about a specific condition or treatment to enable them to make an informed choice. Their job is “to select good-quality research, to provide entertainment, and to be educational, all within a climate of journalists wanting stories that can be ‘summarized in 21 words’ ” (Secko and Smith, 2010). Nelkin (1995) argues that scientists complain about the inaccuracy in the reporting, but admit that, when questioned later, their complaints mainly referred to the problem of omitting details “necessary to place the information in a proper perspective”. (146)

The omission of details that could obscure the clarity of a story is axiomatic to most journalists. In their classic article on news values, Johan Galtung and Mari Ruge (1965) list 12 factors that determine whether a story is covered and how much space is devoted to it. The third is “unambiguity”. In other words, the more complicated and nuanced a story, the less coverage it will get.

Sourcing and accuracy

Many of the academic studies examined confirmed the journalistic behaviour of myself (and most of my colleagues) covering CAM – in that we drew on a range of sources, but most commonly cited conventional medical sources (versus CAM) and used personal anecdotes. In their scoping review, Weeks and Strudsholm (2008) identify 4,454 studies, 16 of which were relevant to their objectives and all published in or after 1998. For articles under 1,000 words, journalists cited conventional medical sources almost exclusively. Only two of the clinical trials reported by the media were published in CAM journals; the rest were published in high-profile medical journals, such as *The Lancet* and the *BMJ*.

In a study comparing the coverage of clinical trials for herbal remedies with the coverage of clinical trials for drugs used to treat the same conditions (Bubela *et al* 2008), the researchers examined 201 pharmaceutical and 352 herbal remedy newspaper articles and found the main source interviewed or quoted for both was a university or hospital scientist or physician. Indeed CAM researchers or practitioners were cited in only 8% of articles on herbal remedy clinical trials.

This is a significant study and the first to systematically compare newspaper coverage of clinical trials for herbal remedies with those for drugs.

They looked at differences in the tone of the stories, and the reporting of trial funding and conflicts of interests. They searched databases for the newspaper articles and used a coding frame to analyse and compare 48 pharmaceutical and 57 herbal remedy clinical trials.

The findings are contrary to most other research discussed in this chapter, which finds that coverage of CAM is more positive than that of mainstream medicine. Bubela and her colleagues found that more stories on herbal remedy clinical trials than pharmaceutical clinical trials stated there was no benefit (29% versus 4%). While the tone of most newspapers that evaluated the outcomes of pharmaceutical clinical trials was “neutral” or “positive”, more were negative about the outcome of herbal remedy trials.

Journalists reported significantly more risks (mainly side-effects) associated with pharmaceutical clinical trials – though 40% of the articles failed to mention any risk at all. Most (83%) failed to mention funding and even more (96%) omitted conflicts of interest.

Journalists reporting on clinical trials, in general, tend to favour positive results, but the researchers found newspaper coverage of herbal remedy clinical trials was more negative than for pharmaceutical clinical trials.

“Indeed, journalists are displaying a degree of skepticism rare for medical reporting. It is possible that once confronted with actual evidence, journalists are more critical or skeptical.” (368)

In an earlier study (2006), Bubela and her colleagues looked at whether clinical trials of herbal medicine and subsequent media coverage in the US, UK and Canada from 1995-2006, was of sufficient quality to provide the public with information needed to make an informed “low risk” decision.

They also found that, despite the fact that there was an increase in clinical trials of herbal remedies, they identified only 58 clinical trials covered by the media. Most research on herbal medicine is published in Asia (mainly China) and some is published in CAM specific journals. But in the media coverage only two were published in CAM specific journals. The majority (86%) were published in conventional medical journals, some with very high impact factors, such as the *BMJ*, the *Journal of the American Medical Association (JAMA)* and *The Lancet*. This reflects a bias toward publishing trials where the lead institution was located in the US, UK or Europe, they suggest.

Yet of the media coverage of these higher-quality trials, over 80% of the articles failed to describe methods of randomisation or double-blinding and over 40% did not mention the use of a placebo. Over 90% did not mention withdrawals and dropouts, while 40% failed to mention the sample size.

They also found that the media “significantly” under-reported risks associated with CAM, and that journalists were more likely to report on clinical trials with negative results, possibly because of their choice of source.

“The conclusion here is that newspapers are not reporting on the facts that the scientific or medical community, and increasingly, the educated and informed public, require to assess the quality of clinical trials...” (5)

Why newspapers choose to cover certain CAM stories and not others is the focus of a study by Lewis, Orrock and Myers (2010), who examined how mainstream newspapers in Australia covered the publication of two peer-reviewed research papers published during February and March 2007 – what the authors refer to as the “Antioxidant Study” (Bjekakovic *et al*, 2007) and the “Prenatal Multivitamin Study” (Goh *et al*, 2007). The first study, published in the prestigious *JAMA*, was a meta-analysis of all the studies looking at antioxidant supplementation; the second, published online in *Clinical Pharmacology and Therapeutics*, was a review and meta-analysis of the prenatal use of multivitamins for paediatric cancers.

The researchers isolated 15 stories about the antioxidant trial and just two about the prenatal multivitamin study. The antioxidant study was accompanied by a press release and flagged up on the main newswire service, Australian Associated Press (AAP) – which, the authors suggest, was one of the reasons for the high number of stories. It demonstrated “an uncritical reverence by Australian medical journalists towards research reports in medical journals like *JAMA*”. Journalists failed to assess the validity or credibility of the research or interview the lead researcher to clarify details and they omitted important details, the authors concluded.

Health journalists place considerable weight on research published in high-impact peer-reviewed scientific journals – sourcing will be discussed in detail later in this dissertation. These journals, despite their flaws, remain the “gold standard” for health journalists, guaranteeing a high degree of scientific rigour and independence, which some might see as lacking in CAM journals that often publish work by researchers with vested interests in CAM, mentioned in the previous chapter. As such, these studies sometimes lacked credibility.

Like most health journalists, I would endeavour to secure an interview with a lead

researcher, even one based overseas. Often, particularly if they were clinicians, they were not available, and if I were working for a magazine or publication of which they had no knowledge, I would most likely not be granted an interview.

In the UK at the time, many of the features about CAM were written by a pool of freelance journalists, myself included, who had some expertise in this field. We would write for a number of media outlets with varying readerships, and would tailor our journalism accordingly, adding more sources, both primary and secondary, for broadsheet newspapers, for instance, and fewer for consumer and lifestyle magazines. Commissioning editors, particularly those on tabloid newspapers and magazines, wanted positive stories – at least in the mid to late nineties. Broadsheet editors wanted more analysis and specific studies to be cited clearly.

This variation in approach was identified by Bonevski and her colleagues (2008) in their analysis of the coverage of news stories of CAM in the Australian media between 1 January 2004 and 1 September 2007. They used a national medical news monitoring website, mediadoctor.org.au³, which monitors, rates and critiques the accuracy and completeness of news stories about medicine and medical treatments, including the coverage of CAM. The rating criteria cover inclusion of newness, evidence, cost and availability, potential harm, independent comment, plus whether the story contains elements of “disease mongering” and is similar to or different from any accompanying press release. Stories were rated “satisfactory” or “unsatisfactory” and given star ratings.

The 222 articles considered relevant were sub-divided into five categories: biologically-based practices, including supplements and vitamins; energy medicine (visible light, magnetism and other electromagnetic forces); manipulative practices (chiropractic, osteopathy, reflexology etc); mind-body medicine (relaxation, hypnosis, meditation, yoga etc) and “medical” systems, such as Traditional Chinese Medicine, Ayurveda, homeopathy, and acupuncture.

They found there was a statistically significant difference between the quality of the reporting on biologically-based practices (high scoring) and energy medicine (low scoring). Statistically significant too were differences in quality between the media outlets (highest scoring – broadsheet newspapers; lowest scoring – television current affairs programmes). Scores also varied for conditions for which therapy was being used (highest scoring – cancer; lowest scoring – paediatric behaviour and mental health).

Almost two thirds of the stories failed to include a comment from an independent expert.

³ It has now ceased due to lack of funding and resources: email communication, Bonevski, 7 January, 2014

Bonevski and colleagues conclude that of particular concern was the failure to mention the costs and potential harm of CAM treatments, given the paucity of information about the safety of many therapies. Four stories had 100% scores for quality, and 19 had scores of between 80-99%, which led the authors to suggest that it is possible to meet most, if not all their suggested criteria. The authors conclude that editorial pressure to produce short stories quickly, poor press releases, a focus on the controversial, and a lack of high-level evidence for CAM in general, might account for the poor scores.

“There is a need to change the methods of promoting research findings within the scientific community, and a need to improve training for health journalists.” (e2406)

In her content analysis of articles about herbal medicine, Lewis (2011) mapped the nature of the media reports about herbal medicine and CAM over four decades from 1966 to 2008 following studies published in the *Medical Journal of Australia (MJA)*. After applying exclusion and inclusion criteria, she examined 148 articles, 70% of which referred to risk – “adverse reactions or events”. Lewis concluded that her study indicated that herbal medicine and CAM “are consistently framed in association with risk more often than any other topic” (214) and postulated that this might be because of the unfamiliarity of herbal medicine and CAM. She observed that this was a field with which most biomedical researchers and practitioners had little knowledge or expertise.

These findings are not surprising. Health journalists covering CAM were more critical of modalities, such as herbal medicine, for the simple reason that they were aware that they could cause more harm to readers than those that were more benign, such as aromatherapy or reflexology. There were any number of biomedical researchers, practitioners and experts whom we could interview to make this point and we always mentioned cost of any treatment we were discussing.

When writing about the use of CAM in the support, or treatment, of serious disease, such as cancer, I was particularly careful. Milazzo and Ernst (2006) examined newspaper coverage of the use of CAM for cancer for three months during 2002, 2003 and 2004 and found and evaluated 310 articles, the frequency of which increased over time (81 in 2002 and 147 in 2004) and of which 38% were published in national newspapers.

The statistics are revealing. Some 45% of the articles focused on complementary therapies as possible treatments for cancer, while 42% suggested that they were useful for palliative care. Over half (53%) of the articles were not supported by trial data and 41% of were “overtly promotional” for cancer care centres, clinics and products. Much of the information about the use of CAM in the treatment of cancer was “seriously misleading” and the authors concluded that cancer patients – and oncologists – were

often ill-informed about CAM and that the reports were “often less than reliable” and had the potential to harm cancer patients (889).

Weeks, Verheef and Scott (2007) undertook a content analysis of 915 articles in the Canadian print media that had reported on the use of CAM for cancer treatment between 1 January 1990 and 31 December 2005. Some 361 focused on CAM as a treatment for cancer; the remainder only briefly mentioned CAM. They found that just over half mentioned potential benefits of using CAM, just under a quarter mentioned risks and just under a third mentioned cost. Few advised readers to talk to a doctor before using the therapy or product. Worryingly, in 40% of the articles CAM products and therapies were described as a potential treatment that could lead to a cure.

Mercurio and Eliot (2011) looked at how the Australian press framed stories on the use of CAM for cancer between 1998 and 2007. They found that the most common frame constructed complementary therapies “as effective and legitimate tools that could safely aid cancer patients”. The second depicted CAM as “normal and necessary” and essential to deal with the “debilitating” and “gruelling” nature of cancer treatments.

A third frame contended that CAM should be promoted within the conventional medical system in the treatment of cancer patients. Australian cancer patients were “missing out” on integrated healthcare – the ultimate fusion of CAM and mainstream medicine – and they ascribed the blame for this on medical practitioners.

The authors concluded that the coverage of CAM in the Australian media was similar to that in the British and Canadian media. Breast cancer was the most “popular” cancer mentioned, journalists frequently employed anecdotes and the term “alternative” was often used when it was presented as just a means of alleviating symptoms. More worryingly, say the authors, was the fact that in two-thirds of the articles, CAM “was explicitly or implicitly identified as potentially curative, often without contradiction or correction” (76). Nearly half of the articles failed to include any mention of risks associated with CAM.

I wrote two features on anthroposophical medicine, one for the *Daily Telegraph* (Rowlands, 1 August, 2000) and one for the *Express* (Rowlands, 1 September, 1999). This is a therapy used to treat serious illness, such as multiple sclerosis, asthma, cardiovascular disease and cancer. Anthroposophical medicines are made from plants, animal and mineral substances. The best known is Iscador, the most common brand of mistletoe extract, used to treat cancer.

It is difficult to say how these features would have fared under the scrutiny of scholars. I

included a positive case history (a woman who recovered from cancer after undergoing anthroposophy), two clinicians, specialising in anthroposophical medicine, and a general physician, who was also a pharmacologist, who specialised in integrated healthcare and was the author of a report commissioned by Macmillan Cancer Relief, *Complementary Therapies in Cancer Care* (1999). I conducted a search on the Medline database, which contains abstracts for biomedical literature from around the world, and I included the following paragraph in the feature in the *Daily Telegraph*.

“But hardcore evidence to back up anecdotal reports is thin on the ground. A Medline search of the last four years unearthed only three papers and one study looking at all the research into mistletoe treatment concluded that the evidence of clinical benefit remains “weak and inconclusive”.

Despite this one paragraph, the feature was positive in its overall tone, as was the feature for the *Express*. There were a number of reasons why I adopted this approach. Anthroposophical medicine is used as a complement to, not a substitute for, conventional practice, so patients were, hopefully, still taking their conventional medication and, according to the Macmillan report, patients with cancer were asking for more information about CAM treatments. Finally, researchers based at two leading London NHS hospitals were coordinating a one-year study looking at how beneficial patients feel anthroposophical medicine actually was. In writing the articles, I took the view that interest among patients and doctors outweighed any apparent absence of evidence.

Anecdotal Evidence

Ernst criticises the media for “relentlessly” promoting CAM through anecdotes (Ernst, 2004), which he writes, as a way of conveying information about health matters on its own, is “utterly meaningless” (254).

Weeks, Verheof and Scott (2007), in a content analysis of 915 articles in the Canadian print media that had reported on the use of CAM for cancer treatment between 1 January 1990 and 31 December 2005, found that anecdotes were the most common sources used to support evidence for the efficacy of CAM in cancer treatment – 49% of the articles used them. But journalists turned less frequently to conventional practitioners to support the information (28%), or researchers (16%), or research published in scientific journals (15%).

They conclude that the findings, citing Hargreaves (2005), might be a reflection of the shift in the focus of the print media from a provider of information to a provider of entertainment. Anecdotes are assumed to increase human interest and consequently the

entertainment value of a story. However, this provides the reader with insufficient information on which to base an informed decision about his or her treatment and this reliance on filtering information – particularly healthcare information – through the prism of personal case histories is increasing, as Coward (2013) notes.

While it is easy for scientists and researchers to criticise the use of case histories in the media, in health journalism, rather than “relentlessly” promoting any treatment or product, the telling of personal narratives is beneficial both for the person relating the story and for the audience (McKay and Bonner, 1999). In the coverage of complementary medicine, such pathologies were far from “utterly meaningless” or merely “entertainment”. As in all health journalism features, these case histories provide a narrative framework around which the research is contextualised. They tell the reader what is involved in undergoing a particular treatment or therapy and whether or not that person derived some benefit from it – regardless of whether or not there is any clinical evidence underpinning its efficacy.

In addition, apart from engaging the audience, including a case history varies the pace of a feature (which could become overloaded with scientific research and expert opinion) and often visually enhances it with a photograph. Sometimes, the journalist writes up the case history in the first-person, which is then added as a “sidebar” or “box-out”, again adding variety to the presentation of the feature.

Weeks and her colleagues (2007) argue that researchers should “strive to develop closer relationships with journalists” and this could be done by “offering their expertise in reviewing draft articles” and using evidence-based anecdotes (research evidence framed as a personal anecdote) instead of interviewing people who had used CAM (937).

This appears to me to be a bizarre notion. I would suggest that this would dilute – indeed, expunge – any human interest element in a story and illustrates a lack of understanding among researchers about how journalists work. In the construction of a case history, journalists “make readers leave themselves momentarily and feel what it’s like to be another person” (Harrington, 1997: xv). How journalists do this – how I did this – is with experience based on years of interviewing people, often traumatised by their illnesses. Case histories offered by doctors are often an amalgam of the experience of a number of patients, so retaining confidentiality. However, such anecdotal evidence rarely breathes life into a story or creates empathy. To make a feature fully engage readers, journalists need to interview their subjects for detail and emotion, as well as for factual information. It is not enough to know that, for instance, a person experiences pain, but when and where they first felt it and how it affects their life.

Sending draft articles to an interviewee to allow him or her to make changes – what is known as “copy approval” – is anathema to journalists. The majority of interviews are “on-the-record” (i.e. the interview is attributed to a named source) and this is agreed between the journalist and interviewee at the start of the interview. As a general rule, sources do not have the right to “copy approval” or “quote approval”, which would allow them to change, tone down, delete, distort or add to an article to suit their purposes. In certain circumstances (usually to check for accuracy) sources are allowed to see copy or quotes, but journalists are not required to alter copy. Occasionally, when writing complex features, I have sent the text to the source I interviewed to check for accuracy only.

Weeks and her colleagues (2007) are correct, however, in stating that presented on their own “anecdotes rarely provide sufficient to support informed treatment decision making” (936). I was never asked to filter a feature through a single case history, however powerful.

In their scoping review Weeks and Strudsholm (2008) conclude that the field would benefit from a theoretical perspective that “linked media production, representation and reception through its relation to culture” (43). They also suggest more “collaborative relationships” between journalists and researchers and researchers and CAM users to ensure research is informed by media practice and vice versa.

While scholars examining media representations of CAM could benefit from meeting journalists who cover CAM (as opposed to undertaking qualitative research), the idea that journalists would forge collaborative relationships with scholars is naïve. All science journalists form collaborative relationships with scientists, and, as Secko and Smith note, “scientists...can exercise judgment by working with journalists they know and trust” (2010: 271). This will be discussed in more detail later in this dissertation.

Jeremy Tunstall, in *Journalists at Work* (1971), criticised sociologists for their ignorance about how journalists work. Tumber used the word “scathing” when he revisited Tunstall’s seminal work (Tumber, 2006). Tunstall wrote that though most sociologists were happy “to absorb a regular daily and weekly ration of journalism, they are remarkably lacking in curiosity as to how news gets into newspapers and on to TV screens. When sociologists do venture opinions about journalism these opinions often reveal ignorance of the most elementary details.” (278). I would argue that there still remains a degree of ignorance among scholars about how journalists undertake their work.

Ernst and Pittler (2006) criticise journalists for linking celebrity with CAM and note that most of the therapies cited were not supported by data from clinical trials, nor do journalists say why celebrities chose a particular therapy.

It is the linking of CAM with celebrity that is crucial, a combination that highlights the fact that the attitude of lay people towards CAM differs from their attitude to conventional medicine. CAM seems more “responsive to fashion” (681) than conventional medicine and celebrities should be aware of their influence in these matters, they conclude.

“We do not normally read in the papers that an actor has taken Imodium or that a singer purchased some Canesten. Yet, like CAM therapies, these remedies are readily available without prescription. It is thus not the celebrity value alone that renders a medical treatment newsworthy.” (681)

However, this linking of celebrity with CAM provides journalists with a news “peg” – a reason to write about the therapy – and also provides editors with an opportunity to publish a photograph of the celebrity, so attracting readers. This was the reason I was commissioned to write about pendants worn by celebrities to “ward off” electromagnetic fields from mobile phones, computers and other technological equipment (“Charms can calm but don’t risk those Rays’, *Daily Telegraph*, 20 August, 2000). The behaviour of celebrities can influence audiences, and as such provides journalists with opportunities to explore the efficacy of CAM therapies, as I did in this feature.

The Coverage of CAM in Magazines

Research into the portrayal of CAM in magazines is “scant” according to Clarke *et al* (2010). They examined 37 articles found in magazines with circulation rates greater than one million published in the US and Canada from 1980-2005. Like other researchers, they found a growth in the number of articles on CAM over time.

They identified three themes in the articles they examined. The first was that CAM should be used only in conjunction with conventional medicine, was potentially dangerous and lacked empirically-based evidence to back up its claims. The second, one not mentioned by other researchers, was the veneration of individualism and consumerism.

The third theme was cost, of which they found little discussion, although in some articles CAM was described as providing a cheaper alternative for poorer, uninsured people (this was a US study). It was not a choice for people from lower socio-economic groups. Several articles questioned the profit motive of the manufacturers

of CAM products.

The authors concluded that CAM was presented as “good”, but not as good as conventional medicine. It was described as “holistic”, not because it took into consideration the individual in the context of family, friends and community, “but because it emphasizes the glorification of the individual who is seen not only as a biological organism...but as a complex whole, composed of body–mind–spirit” (129).

They suggested that the emphasis on the individual as an active consumer, linked to the appeal of freedom of choice may “represent an indirect way of buttressing capitalism and both conventional medicine and CAM” (129). They cited Goldstein (2002) who suggested that there were significant economic forces behind the growth of CAM and that major global institutions, such as medical associations, the pharmaceutical industry, insurance companies and internet providers, could benefit from the promotion of CAM.

Kirkman (2001) explored how health practitioners were portrayed through letter or advice columns; human-interest or first-person features; health features on a specific condition and advertisements, which frequently included health products and services.

She looked at women’s popular magazines in New Zealand from November 1997 to November 1999. She noted that in all of them, CAM practitioners were gaining equal recognition with medical practitioners and reference to the actual research studies was provided, and this was the rule rather than the exception.

Dunne and Phillips (2010) conducted a content analysis of three popular Australian magazines published between January and June 2008. They found 220 references to CAM, most made in passing, rather than being the subject of the article, and most referred to biologically-based therapies, such as dietary supplements and herbal products. Some 81% of these references were positive. Like much coverage at the “softer” end of CAM journalism, they found that biological explanations for how a therapy actually worked were superficial (“boosting the immune system” “improving circulation”).

They argued, citing research by Long (2010), that users developed “critical health literacy”, increasing their engagement with their own healthcare. Doctors were portrayed as “distrustful” and “disrespectful” of CAM, and as Australians make almost as many visits to practitioners of CAM and they do to physicians, this could result in patients excluding doctors from discussions about merging CAM and biomedical treatments.

The final paper in this review, focusing on magazines, is one by Doel and Segrott (2003). They undertook a textual analysis of 20 British health and lifestyle magazines and interviewed eight editors, one of the few group of researchers that did so.

They suggested that the magazines framed CAM in three specific ways – as “a pragmatic medical tool kit” to alleviate symptoms and potentially cure illness; as a mechanism to broaden an understanding of health and wellbeing and as a main pillar of an alternative lifestyle that radicalises and empowers consumers. CAM was framed as a way of coping with “everyday urban life”. It treated specific diseases but also “the more general and diffuse sense of existential dis-ease”.

These findings again reflect my experience writing for consumer magazines. The relationship between the journalist and the reader is more intimate and “pseudo-personal” (Holmes and Nice, 2012) than that between the journalist and the newspaper reader. Journalists frequently use the personal pronoun, and giving the reader a sense of empowerment is paramount. The tone and style of features are more relaxed than newspaper articles and references to research studies are more generalised (“studies/experts say”).

Weeks and Strudsholm (2008), in their scoping study, conclude there is little evidence of any great academic interest in exploring media coverage of complementary and alternative medicine. This may be because it straddles too many disciplines.

Chapter 4: Covering CAM: a critical appraisal

I have written on approximately 30 therapies in various publications, either as a single modality or focusing on how a particular therapy might support a specific condition. I have undertaken research on 19 supplements, plants and herbs for national newspapers.

Writing about complementary and alternative medicine had far more challenges than writing about mainstream medicine for three reasons: the difficulties around sourcing (both secondary and primary); the eagerness of publishers and commissioning editors to succumb to the CAM juggernaut and present CAM as a viable complement (though rarely an alternative) to mainstream medicine – and the steady seduction of journalists by CAM organisations and public relations companies.

In the course of writing about CAM, I have been told by editors to adopt a more “positive” tone, to cover therapies that were marginal (flower remedies, crystal therapy, gem healing) and used by a minority of consumers, had a lengthy section on the placebo response removed from one book and my views, based on interviews with high-profile CAM researchers, toned down or expunged. I shall examine these challenges in this section, and later, when I relate my work to the academic literature on sourcing, framing and why people believe things for which there is no evidence.

Good editors always query copy. What exactly is the impact of drug x on neurotransmitters? Why and how do probiotics have a beneficial effect on gut flora? Yet, not one of them queried the mechanisms behind the invisible meridians and chakras – respectively “pathways” and “holes” in the body through which CAM practitioners claim energy courses in, out and along. They never asked why people, intelligent and rational in other areas of their lives, would lie, covered in crystals on a couch or have the balls of their feet pressed and told that this would help clear the “blockage” in their gall bladder.

I had no answers, and editors knew this – and besides, it was too good a story to miss. They were adhering to established news values, outlined by Galtung and Ruge 60 years ago:

...“once something has hit the headlines and been defined as ‘news’, then it will continue to be defined as news for some time even if the amplitude is drastically reduced.” (Galtung and Ruge, 1965: 67)

My journalism, whether in conventional medicine or CAM, has been long-form journalism – books, or features commissioned by health page editors. Breaking news in medicine was confined to the news pages (Vastag, 1998), but the health pages, a relatively new addition to national newspapers in the late twentieth century, was the

home of longer, single-issue features, focused on one condition, or in the case of CAM, one modality.

I am not a scientist, nor do I possess a journalism qualification. My first and second degrees are respectively in Combined Studies (English Literature, American Studies, History and Sociology) and English Literature. I completed a short certificate in journalism at the (then) London College of Printing and went straight into magazine journalism. I have worked on business-to-business publications, consumer magazines, newspapers and news agencies.

I began my freelance career in 1980, first as a general feature writer. From 1990 I started to focus on health, building up my specialist knowledge experientially and through membership of organisations, such as the Medical Journalists' Association (MJA) and later the Guild of Health Writers (GHW). I wrote for national newspapers, the specialist and business-to-business press and consumer magazines.

My drive as a journalist is to inform (and therefore empower) an audience about conditions of which they might be unaware, and about new treatments. As an example, I wrote a feature for *The Observer* that exposed the fact that thousands of women were undergoing unnecessary hysterectomies for fibroids, which could be safely removed by an alternative, less invasive procedure, one not undertaken by gynaecologists ('The Unkindest Cut', *Observer*, 28 June 2001). Another article, published in the T2 section of *The Times* and again in *The Independent*, alerted readers to the fact that heart attacks kill four times as many women as breast cancer, and the symptoms are not the same for women as for men ('Women are dying because this disease isn't diagnosed', *Times T2*, 18 October 2005; 'A Silent Killer', *The Independent*, 30 October, 2007).

Complementary and alternative medicine is a field where its critics regard it as "akin to voodoo" and its proponents would entrust their child's health to it (Singh and Ernst, 2008: 2). I am a journalist and sceptic and persuaded by evidence. My scepticism, as Michael Shermer (2002) outlines, is embodied in the scientific method, which involves gathering data to confirm whether or not a treatment is efficacious and safe, from those researching and practising in the field, whether they are practitioner/researchers or scientists. The trick, as Shermer states, is "to navigate the treacherous straits between 'know nothing' skepticism and 'anything goes' credulity by continuously and vigorously applying the methods of science". (Shermer: 18)

I completed the two books at the height of a lively academic debate about objectivity and relativism, science and postmodernism. The influential *The Structure of Scientific Revolutions* (1962) by Thomas Kuhn, a physicist, who later became a philosopher, argues

that development in any scientific field happens via a series of phases. This “normal science” is based on prior scientific achievements, acknowledged by the scientific community, which form an intellectual paradigm or “disciplinary matrix” that supplies the foundation for its further practice and development.

The paradigm, says Kuhn, legitimates “puzzles and problems” that are taken for granted and assumed to have solutions by the scientific community. Such communities, Kuhn argues, consists of practitioners of a particular specialism who have undergone the same education, professional initiations, absorbed the same technical literature “Communities of this sort are the ...producers and validators of scientific knowledge.” (177)

Kuhn writes that the “striking feature of normal research problems...is how little they aim to produce major novelties, conceptual or phenomenal” (35). Real breakthroughs come when the methods legitimised by the paradigm deliver too many unresolved anomalies. These accumulate and in the end the problem is solved by a “paradigm shift” in which the old paradigm is replaced by a new one.

This complex relationship between scientific work (construction of facts, evidence) and scientists themselves, was examined Bruno Latour, a sociologist and philosopher, and Steve Woolgar, a sociologist, in *Laboratory Life: The Construction of Scientific Facts* (1979). They concluded that scientific facts are socially constructed (as the title suggests) and are produced by a network of “agents”, which include technicians, laboratory equipment and investors, as well as scientists themselves.

Experienced medical journalists understand that most scientists and clinicians are competing for funds and prestige, are often funded by pharmaceutical companies, are constrained by peer-group pressures and are building or guarding their reputations by holding specific views on approach and treatment. This does not invalidate their work. The same, to a lesser extent, is true of CAM practitioners, with a major difference being that such practitioners are unregulated.

Phillips (2014) writes that for liberal, professionalised journalists, “the gathering of facts, obtained via a range of identifiable and *verified* sources” (my italics) is the ideal (40). While being aware of the social pressures and constraints on sources – which does not necessarily impinge on the credibility of their research – journalists, myself included, will always choose the most authoritative, recognizable and verifiable source.

I found a genuine desire among some scientific researchers, such as Ernst, to test these therapies to see if they had any benefit – even in the absence a biomedical mechanism. Ernst became one of my main credible expert sources *because* he was a medical clinician,

trained in Germany, but who had also received training in acupuncture, autogenic training, herbalism, homoeopathy, massage therapy and spinal manipulation. He was professor of complementary medicine at Exeter University, determined to apply scientific scrutiny to CAM therapies. He maintained he had (and has) no conflicts of interest.

As such Ernst was not opposed to CAM. I interviewed him in 1996 for *The Which Guide* and again for the feature for the *Daily Mail* (see Volume 2) and his views had not changed.

“I am not anti complementary medicine. If anything, I am mildly in favour of homeopathy because that is what I learnt at one stage and why should I be anti it? My interest is to find the truth in order to improve healthcare for tomorrow and create an evidence base.

(interview, November 2006)

As a journalist, writing for large audiences, it would be have been unethical to write about a particular therapy, without informing the readers that while many people may have derived benefit from a particular modality, there was no evidence that it worked.

I would argue that medical researchers and clinicians do work within paradigms, continually replicating and testing clinical studies. When, as Kuhn writes, the anomalies become too great, such paradigms are overturned by scientific methodology. It is often journalists who raise questions about these paradigms and who sift through clinical trails for such anomalies and expose them. The theory that there is a link between high levels of cholesterol levels and heart attacks, for instance, which has led to an increase in the prescribing of cholesterol-lowering drug, has been questioned by journalists, as well as scientists.

When it came to CAM, I believe there was a paradigm shift – but it was not among the scientific community, which continued to adhere to its traditional paradigm – evidence-based medicine. They found, and continue to find, little rigorous evidence for the efficacy of most therapies, above a placebo response, let alone a biomedical explanation. The shift was cultural and sociological.

I am less positive about CAM now than I was in 1996. Since then, researchers have conducted many more clinical studies examining the efficacy and safety of a number of CAM therapies for various conditions, but the most persuasive are the systematic reviews⁴, and meta-analyses⁵, which have shown most CAM therapies to be ineffective or effective for only some conditions (Ernst, 2002; Madsen *et al.*, 2009). Yet in many

⁴ a review that summarises the current literature on a specific research subject.

⁵ a statistical technique combining the findings of several studies

ways my views remain the same, despite some positive studies on CAM being overturned. They are encapsulated by Ernst in my interview with him in 1996 and in his essay, 'Complementary medicine: common misconceptions' (2008).

"The whole field of complementary medicine carries a very small risk but that's because it is pretty useless and useless treatments are likely to be pretty safe. They don't alter the course of the disease. You will get benefit if you have the right kind of hope and encouragement, if someone gets you to relax, physically and mentally...What people are paying for is tea and sympathy and a bit of a chat." (interview, Ernst, February 1996)

"In fact, there are now thousands of clinical trials and in excess of 500 systematic reviews on the subject, many of which suggest that some CAM interventions do generate more good than harm." (Ernst, 2008: 528)

In other words, I believe some forms of CAM are demonstrably effective for some conditions, but many are not. Some can alleviate anxiety (and consequently anxiety-related disorders) but they do so because they are strongly branded as therapeutic and delivered (usually) by empathetic practitioners for whose time and 'expertise' the consumer pays. This is all that is required for a strong placebo response.

My approach was the same when it came to reporting on CAM as with conventional medicine. I undertook sufficient research from multiple sources to present the audience with as accurate a picture as I could. My work in this field, particularly when it came to *The Which Guide?* was exhaustive and I was one of the few journalists working at the time to undertake such rigorous research.

What interested editors was whether a particular therapy or remedy was value for money, whether one therapy was better than another for a particular condition and whether the practitioner or therapist belonged to a nationally-recognised body that (they reasoned) would be some sort of guarantee of safety. What rights, if any, would a consumer – and they were consumers rather than patients – have if he or she were harmed?

I shall now look in detail at how I conducted my journalism in this field. To examine different challenges around journalism in this field, I shall look at three therapies – acupuncture, transcendental meditation and Traditional Chinese Medicine. I shall also examine how I covered supplements.

Sourcing "general" CAM

This term is used by Vastag and his colleagues (1998) to denote CAM being reported as a single therapy, such as chiropractic. In their analysis they found this to be the most popular way that coverage of CAM was delivered, and I found this to be true. Editors

were interested in features on the major therapies themselves – acupuncture, homeopathy, herbal medicine and so on. There was little interest in the more esoteric modalities. So while rejecting those therapies that could be easily dismissed as “quackery”, by implication they lent weight to the “mainstream” therapies.

My sources can be divided into five main groups, similar to those outlined by Vastag.

1. *Complementary and alternative medicine sources*: individual therapy organisations, practitioners, consumers, advocacy groups, private CAM companies, umbrella organisations representing CAM.
2. *Conventional medical sources*: BMA and the Royal colleges, specialist consultants, researchers and academics, conventional healthcare providers and specialists.
3. *Legal & political sources*: Department of Health, regulatory agencies, medical negligence lawyers, patient advocacy groups, consumer protection specialists.
4. *Media sources*: editors, authors, journalism colleagues, newspapers and specialist and consumer magazines, press offices and public relations organisations.
5. *Sceptic groups*: HealthWatch in the UK and Quackwatch in the US. The latter was established in 1996 by Dr Stephen Barrett – too late for my research for *The Which Guide?* – but I referred to publications, such *The Heath Robbers* (1993), which he co-edited, and *Examining Holistic Medicine* (1989).

To build up my expertise, I had joined the MJA, but because of my interest in CAM, in 1994 I was invited to the founding meeting of the Guild of Health Writers. While it was not set up directly in opposition to the MJA, in its seminars and workshops it sometimes included an examination of how CAM could be integrated into the practice of mainstream medicine. It had an associate membership category that welcomed CAM therapists, as well as medical practitioners, who were also established writers, journalists or broadcasters.

Members were freelance journalists, like myself, working for national newspapers or magazines, commissioning editors and publishers of health magazines. Membership gave access (as it did with the MJA) to a directory, listing members’ contact details, together with their areas of expertise, which was bought by public relations companies.

As a member (and later vice chair) I was part of a cohort of experienced health journalists, who regularly exchanged information and views on what we regarded as a good source or solid research. Such journalists were rarely scientists, but usually arts graduates and/or trained in local newspapers and had experience in business-to-business publications, such as *Pulse*, *GP*, *Doctor* and *Hospital Doctor*.

Pinning down Acupuncture

The growth of complementary therapies spawned the formation of several umbrella organisations, such as The British Complementary Medicine Association, The Institute for Complementary Medicine (ICM), The Natural Medicines Society (NMS) and The Council for Complementary and Alternative Medicine (CCAM), which represented the interests of practitioners. All were established between 1981 and 1990. I contacted all of these bodies to find out major organisations in each therapy – and a “trusted” source, often Prof Ernst, to find out which of the umbrella organisations were the most credible.

Each therapy usually had a number of, often rival, umbrella organisations, each vying for power and prestige, and acupuncture was no different. There were two acupuncture organisations – the British Medical Acupuncture Society (BMAS) and The British Acupuncture Council (BACc) that represented the two “branches” of acupuncture – respectively “medical acupuncture”, practiced by doctors with additional training in acupuncture, and traditional Chinese acupuncture. The difference was in diagnostic and needling techniques.

There was growing evidence that acupuncture might alleviate some forms of pain. However, much of the information I received, along with references to research, came from these two organisations, both of which had vested interests. My journalistic inclination was to privilege “trusted” sources and medically-qualified practitioners and my main source was Dr Adrian White, a physician, acupuncturist, research fellow and leading investigator into acupuncture, based at the Centre for Complementary Health Studies at the University of Exeter. I visited him on 18 April 1996 and conducted an interview.

Gathering research evidence 20 years ago was difficult. Dr White generously provided me with a number of research studies, but he later wrote:

“I have to say I got a ‘rocket’ the next day for letting you make photocopies of articles which the Department has paid for, and which are actually copyright! I defended myself by saying that the more we were able to help you, the more likely it was that the book would be objective.” (personal communication, 22 April 1996)

I consulted research on the risks of acupuncture (Ernst, 1994), interviewed the heads of both acupuncture organisations and other research academics, such as Dr David Peters of the Marylebone Health Centre, part of the University of Westminster, and Dr George Lewith of the Centre for the Study of Complementary Medicine, Southampton. Both were qualified in medicine and various complementary therapies and both were academics.

I referred to several books written about acupuncture, as well as two “sceptic” books (Butler, 1992; Barrett, 1993). HealthWatch, set up in 1989, whose members included doctors, lawyers, scientists and journalists, underpinned much of my thinking. HealthWatch’s mission statement, outlined in its publicity leaflet, was the promotion of high standards of healthcare by practitioners and rigorous testing of treatments. It published a newsletter four times a year and regularly ran articles critical of complementary medicine (‘Risks of Fringe Medicine Are Ignored’, February 1995, newsletter 17; ‘Acupuncture – Elusive and Exciting?’ October 1995, newsletter 19). Its chairman, Dr Thurstan Brewin, a consultant oncologist, was a trusted source.

Despite this detailed research into just one therapy, my editor at the Consumers’ Association would fax me an exhaustive list of queries, many of which were justified, and others which were not. I shall discuss these in a later section on framing.

Mediating Meditation

It is hard to believe that meditation, now a mainstream activity, was seen as esoteric and slightly cranky. Since 2004, mindfulness, a form of meditation based on Buddhist practices, has been prescribed on the National Health Service for anxiety and depression and the evidence for its benefits appears to be sound (Piet and Hougaard, 2011; Krusche *et al*, 2013).

In 1996 it was very different. There was little or no research to back up the benefits of mindful meditation (then known as Buddhist meditation) and the most popular form was Transcendental Meditation™ (TM), developed in 1960 by the Maharishi Mahesh Yogi, founder of the Maharishi International University, now the Maharishi University of Management.

I have written on meditation a number of times, but I will focus on the chapter for *The Which Guide?* For this I interviewed TM’s UK press agent, who sent me extensive material on research that underpinned the benefits of TM. I also interviewed Dr Nicholas Argyle, a consultant psychiatrist at Northwick Park Hospital and president of the British Association for the Medical Application of Transcendental Meditation and Dr Peter Warburton, also involved in the TM organisation and now chairman of Maharishi Foundation UK. I also interviewed the head of the Friends of the Western Buddhist Order (FWBO), which ran courses in Buddhist meditation and The School of Meditation in London, which was similar to TM, in that you meditate on a sound.

Secondary sources, were *Full Catastrophe Living* (1990) – now a classic on the practice of mindfulness – by Jon Kabat-Zinn, and *Timeless Healing* (1996) by Dr Herbert Benson. Dr

Benson, whom I interviewed, was a cardiologist and founded the Mind/Body Medical Institute at Harvard Medical School. I also interviewed the psychologist Dr Susan Blackmore, who researched the paranormal, near-death and out-of-body experiences. The difficulty here was that the wealth of research into the benefits of meditation was conducted by one organisation and most of the researchers belonged to the Maharishi Foundation. Apart from the work undertaken by Kabat-Zinn and Benson, there was little or no research into the benefits of mindful meditation or that practiced by The School of Meditation.

To me, there seemed little difference. In TM and meditation taught by The School of Meditation, the meditator focused on a word or 'mantra'; in Buddhist meditation, one focused on the breath. However, there was a difference in cost. A course in TM in 1996 cost £490 for an introductory session, four sessions on consecutive days and a further session three months later. A six-week course in Buddhist meditation (2.5 hours a week) cost £60 and The School of Meditation suggested a one-off donation of one week's income (Rowlands, 1997: 191-192).

In the chapter, I described the different types of meditation, its history, cost and whether or not it worked. I included the following paragraphs:

"Most of the studies attesting to the benefits of meditation relate to TM. This is not necessarily because TM is better than other forms of meditation, but because the TM organisation has the money to conduct major scientific trials...

Scientific studies by non-TM people show very different conclusions. TM does reduce stress and is relaxing, but no more than sitting down and either reading a book or just doing nothing. Moreover, no evidence exists that TM is better for you than any other form of meditation. In any case, meditation is less effective in lowering blood pressure than exercise." (Rowlands, 1997: 190)

These anodyne paragraphs resulted in a formal complaint from the TM organisation. I learnt from one of the contacts I interviewed that it was a tactic of groups, like the TM organisation, to "bombard critics with letters/information" (communication to Vicky Fisher, Which? Books, 1 February 1998).

In my hierarchy of sources, as a journalist and a science journalist, I relied on academics for unbiased scientifically accurate information. In the case of TM, it was Dr Susan Blackmore, Dr Michael Delmonte, a clinical psychologist at St Patrick's Hospital, Dublin, who had written two theses on meditation and around 50 research papers, Dr Benson and Professor Michael West, a research psychologist.

I wrote to my editor, who had the unenviable task of responding to the TM organisation,

quoting my sources:

“There are lots of studies to show that TM is no better than any other forms of meditation. The Maharishi International University has huge financial interests, is very strong and enormously powerful” (Blackmore. Personal communication to Gill Rowley, Which? Books, 1 February 1998).

“In the scientific community we would view with narrowed eyes research emanating from the Maharishi International University on meditation...They have devised a method that is stress-reductive – there is no doubt about that. But to say in a child-like way ours is better than yours is not on...There is no consistent evidence” (Delmonte. Personal communication to Gill Rowley, Which? Books, 1 February 1998).

This exchange symbolised the difficulties any journalist covering CAM faced. On one side, there were CAM organisations and practitioners, with vested interests, who believed passionately in their modalities and supplied what they regarded as sound research to support their claims. On the other side, there were scientists and researchers who took an evidence-based view of these therapies and were critical of those that had little scientifically robust evidence to support them.

This unwillingness to consider criticism and squelch any that does arise is a “telltale” sign of a cult, argues Shermer (2002). I experienced the same kind of treatment following the publication of an interview I conducted with Professor Ernst (‘Useless. Dangerous. Even crooked. The brutal verdict on our most popular complementary cures - by Britain's foremost expert’, *Daily Mail*, 12 December, 2006: 42, see Volume 2).

Detoxifying Traditional Chinese Medicine

Much of the research in the field of CAM focused on ensuring patient safety, warning readers against quacks selling snake oil, “remedies” containing toxins and shavings of the body parts of endangered species, and steering them away from practitioners devoid of qualifications. A practitioner registered with a professional body was less likely to damage a patient either financially or psychologically than one who was not.

Trusted, reliable information was badly needed. A survey of 145 general practitioners in the Avon area of west England, carried out in 1986 showed that only 5% of British doctors claimed more than “a poor knowledge of herbal medicine” (Wharton and Lewith, 1986). Few knew anything about herbal medicine and most regarded it as a medical residue from the past – harmless, but ineffective. Yet, as Griffin and D’Arcy point out, both patients and doctors were “misinformed since many herbal products can be exceedingly toxic and may indeed present peculiar hazard if taken in combination with orthodox medicines”. (1997: 65)

National newspapers regularly ran news stories on Traditional Chinese Medicine (TCM), such as that of eight-year old Nicola Yeatman, from Lydney, Gloucestershire, who was “cured” of her severe eczema by drinking a brew of Chinese herbs dispensed by a TCM practitioner, Mrs Ding Lau (*Sunday Mirror*, ‘Chinatown Cure’, 13 May 1988).

The reason for this increased interest was the fact that Chinese herbal medicine was one of the fastest-growing complementary therapies in the West with 260 registered TCM herbalists practising around the UK, between them dispensing about one million prescriptions in 1995 (Rowlands, 1997: 105). Media reports claimed there were around 600 Chinese herbal clinics established in Britain, and three colleges in or near London teaching TCM had recently opened (‘Lizards for asthma, antlers for the kidneys’ *The Independent*, 7 December 1993: 22; ‘Full of Eastern Promise’, *Daily Mail*, 4 July, 1995: 46-47).

When it came to TCM, safety was more important to editors than efficacy, and rightly so. Large amounts of traditional medicines were being imported into Britain legally and illegally, some of which were contaminated with poisonous metals, such as lead, arsenic and mercury, and conventional drugs, such as benzodiazepines and paracetamol. In a comment article, Dr Atherton (1994) called for a formal system of reporting adverse reactions and emphasised that practitioners of mainstream and traditional medicine needed to be aware of the risk of receiving simultaneous treatment.

Consequently, I interviewed regulatory agencies, as well as researchers, practitioners and the head of the Register of Chinese Herbal Medicine, which, according to my sources, maintained minimum standards of training and practice. The toxicologists at the Medical Toxicology Unit (MTU), now the Medical Toxicology Information Services, (MTIS), were important sources for all my work on herbal medicine.

In 1996, the MTU produced a report based on research conducted between 1991 and 1995, on the health effects from traditional remedies and dietary supplements. These interviews and the final results were invaluable and underpinned the chapters on herbal medicine and Ayurvedic medicine in both books (Rowlands, 1997: 103-104; 108-111; Rowlands, 1999: 115). The report identified cases where certain Chinese herbal medicines were shown (possibly) to be associated with liver damage, and underlined the confusion around the legislative division between foods and medicines, which I endeavoured to clarify in Chapter 5 of *The Which? Guide* (1997: 49-68). I used this material along with research conducted by Peter De Smet, a Dutch pharmacist and clinical pharmacologist at the Royal Dutch Association for the Advancement of Pharmacy (De Smet, 1995).

Turning to efficacy, my main source was Dr David Atherton, a consultant paediatric dermatologist, who then, as now, practised at Great Ormond Street Hospital for Children. He and his colleagues wrote and contributed to a number of studies, which persuasively demonstrated the efficacy of Chinese herbal medicine on widespread and severe atopic eczema (Sheehan and Atherton, 1991,1994; Sheehan *et al*, 1992a, 1992b, 1994, 1995).

Though there was evidence that TCM could improve eczema (Rowlands, 1997: 108) the issue of safety overshadowed that of efficacy, as it did in my work covering other therapies, particularly hypnotherapy. In the hands of a trained hypnotherapist, working closely with a consultant gastroenterologist, “gut-directed hypnotherapy” can alleviate the symptoms of irritable bowel syndrome (Gonsalkorale, 2003); an untrained hypnotherapist, working alone, can sometimes be dangerous, “reopening” repressed memories and planting false ones (Rowlands, 1997: 166).

The challenge in working for the Consumers Association was that every chapter was sent to a “checker”, often the head of a CAM organisation, who would often disagree with some of my evidence-based statements. In the chapter on colonic hydrotherapy, for instance, I submitted the following paragraph to my editors:

While there is no evidence that colonic hydrotherapy does you any harm, careless use of any colon cleanout may deplete you of salt, water and potassium. There is no scientific evidence that colonic hydrotherapy does you any good. If the water pressure is too high, it can perforate the colon. (fax to Which? Books, 4 October, 1996)

The checker replied:

The pressure used is half that of a barium enema. In scanning the literature we find no evidence of perforation. There is scientific evidence that it does not disturb the electrolytes’ balance. (ibid)

I would then provide my editors with references of peer-reviewed studies and transcripts of interviews I had carried out, in this case with gastroenterologists.

Sourcing Supplements

I was one of a handful of health journalists who investigated whether or not there was any evidence behind supplements – not just herbal products, but vitamins, and chemicals, such as glucosamine.

The use of herbal remedies and supplements, often referred to by practitioners of herbal medicine as “phytomedicine”, was widespread across Europe and the total over-the-counter market for herbal remedies in Europe was £1.45bn (Fisher and Ward, 1994). In the UK, the licensed market for herbal medicines was estimated to be worth £38 million

in 1996 – half of the total market for complementary remedies – and the general public was using them to complement or replace conventional medicine (Barnes *et al*, 1998).

Consumers were liberally self-medicating with these supplements and what concerned me was that extracting and synthesising an active ingredient might not be as beneficial, or work in the same way, as eating the whole plant. In large doses and over time, it could be toxic. Moreover, other constituents in the plant might be important in the synthesis of the active ingredient and taking a cocktail of herbal supplements might be harmful in interaction with each other and/or with conventional drug therapy.

The *Daily Telegraph's* "Does it Work?" column ran every week on its health pages during the late 1990s in an attempt to inform readers about the efficacy (or not) and risks of these supplements. I wrote 19 of these columns, the subjects ranging from herbal supplements, such as Devil's Claw, claimed to alleviate joint pain, to foods, such as ginger and cranberries, claimed (respectively) to help nausea and bladder infections. These columns were around 600 words long and rigorously researched (see Volume 2).

I will look at how I sourced these features with particular reference to an article I wrote for the health pages of the T2 section of *The Times* on echinacea ('A Remedy That's All in the Mind', *The Times T2*, 18 May 2004), claimed by herbalists to be good at preventing the common cold, and with general reference to the features I wrote for the "Does it Work?" column.

Following the commission from T2, I did an initial search on the US medical database, PubMed, as I did with all these supplements. One recent study concluded that echinacea failed to prevent infection with a cold virus and I conducted a short interview with the lead researcher. Another found that echinacea failed to prevent colds in children. Both had been published recently and in high-profile medical journals – *Clinical Infectious Diseases* and *Journal of the American Medical Association (JAMA)*.

Like all studies on plants, finding definitive research was problematic, as I outlined in the feature. My major source for a feature like this would be a research scientist and leading expert in the common cold. Professor Ron Eccles, head of the Common Cold Centre in Cardiff, was ideal. I had interviewed him before and knew him to be articulate and able to couch scientific research in language easily understood by a lay audience. The BMA press office supplied me with other experts. I also contacted Prof Ernst.

I interviewed Dr Jen Tan, the director of Bioforce, the Swiss company that made Echinaforce, one of the main brands in the UK. I had met him during a tour of the manufacturing plant in Switzerland. His public relations company sent me a statement in

which he conceded that some echinacea products work and others, because of manufacturing reasons, failed to do so.

Prof Ernst had told me that echinacea, as a stimulant, could have “profoundly negative effects” and should not be taken for “long periods of time”.

“You shouldn’t take it as a blanket cover, because it could have detrimental effects. If you tamper with your immune system it could have all sorts of effects.” (interview, Ernst, April 2004)

However, I needed a variety of sources, and on the recommendation of the BMA press office, I interviewed Dr Jonathan Brostoff, professor of allergy and environmental health at King’s College, London, who provided the quote I needed.

“The downside of echinacea is that it does have ephedrine and adrenaline compounds, which are natural stimulants, so that it could do harm as well. The fact that it’s taken so widely and that people don’t regularly comment on the downside effect of it suggests that it’s relatively harmless. However, there is no database, no drug information sheet where you can report adverse effects, like you can with ordinary drugs.” (ibid., *The Times T2*)

Filling a feature with conflicting views is unsatisfying for the audience. I wanted to end it on the view that if echinacea had any effect it was likely to be a placebo response – and this was the view of both Ernst and Eccles.

The number of sources I included in the “Does it Work?” column varied with each article, but the pattern was the same – an examination of high-impact peer-reviewed journals for the latest studies, plus an interview with the lead researcher; interviews with independent experts (medical consultant, toxicologist, pharmacognocist⁶); data from relevant commercial organisations and interviews with their chief executives or chief scientific advisers. Occasionally, I would interview a case history.

Criteria for inclusion were new research, product launches and public interest. As I mentioned earlier, there was concern among editors about the proliferation of supplements and the need for readers to be fully informed. I include two features from this column in Volume 2 – one on globe artichoke supplements and one on nettles. For the latter I interviewed a professor of pharmacognosy, a herbalist and spokeswoman for the National Institute of Medical Herbalists, and a senior lecturer in nutrition at a leading university; for the former (the generation of which I will discuss in the next chapter) I interviewed the same nutrition expert. For both features, I examined secondary sources and for both I included information about products. I also wrote about glucosamine, a

⁶ A specialist in the study of medicines derived from plants and other natural sources.

remedy claimed to ease joint pain, for which I interviewed a chiropractor, a consultant rheumatologist and a case history. For ginger, I interviewed a director of Raynaud's & Scleroderma Association⁷, a pharmacist, provided by the press office of the Royal Pharmaceutical Society and an academic.

Sourcing information on supplements was always challenging; sources themselves could become tainted by the lavish hospitality of supplement companies, even though no fee may have been attached for their expertise. I would name products I felt to be superior to others to benefit readers, although this practice is not usual in medical journalism – the generic name of a drug, such as fluoxetine, is normally mentioned, rather than its brand name – Prozac. I shall discuss these challenges in detail in the next chapter.

⁷ Raynaud's disease affects circulation in the extremities. Ginger is claimed to alleviate this.

Chapter 5: How my journalism in CAM relates to scholarship in sourcing

To complete *The Which? Guide* I conducted approximately 60 interviews. For *Alternative Answers to Asthma & Allergies* and for my journalism for national newspapers and consumer magazines, I re-interviewed contacts and undertook, at a conservative estimate, around 100 more. I referred to many clinical studies, between one and four for each feature, used material from press releases and attended press conferences and press trips.

Most of the scholarship around sourcing practices focuses on the source-journalist relationship in politics and crime and the production, by reporters, of news. There is little about journalists working as feature writers, less about journalists working for magazines – and almost nothing about what some journalism academics disparagingly refer to as “anecdotal evidence”, despite the fact that stories detailing intimacies and difficult situations are the staple fare of contemporary journalism (Coward, 2013). Science news reporting is reactive, driven by the daily diary (Williams and Clifford, 2009); feature writing focuses on off-diary stories, which journalists invariably glean from their contacts or from secondary sources ignored by news reporters.

Complementary and alternative medicine is not hard science; in some ways, it is like a designer garment, bought by those who can afford it to give them pleasure and make themselves feel (temporarily) better. Nevertheless, it can cause financial, physical and emotional harm and so to write about the subject in any meaningful way, I approached it as a specialist science journalist and used secondary and primary sources in the field of medicine.

In this section, I shall examine how I sourced my journalism in CAM by referring to academic literature in the field of sociology, media studies, cultural studies and science journalism.

Secondary Sources

Science correspondents and reporters routinely scan every issue of the *BMJ* and *The Lancet* for stories and regularly look at other high-profile medical journals, such as *JAMA* and *The New England Journal of Medicine* (Wilkie, 1996; Entwistle, 1995; van Trigt, 1994). These journals are part of the “beat”, recognised as authoritative and likely to contain new information, eminently publishable because independent peer review gives the journals an “independent stamp of approval”. Bartlett (2002) found a high percentage of medical news stories originating from medical journals such as the *BMJ* and *The Lancet*.

In their in-depth interviews with seven medical journalists who wrote for Dutch newspapers, van Trigt and his colleagues (1994) reported that two reasons were given for the importance of these journals: firstly, that they described the most important developments in the field and, secondly, that research was peer-reviewed by experts, giving the journalist a reasonable guarantee that the study had been performed properly and the conclusions drawn correctly. Journalists, in general, see no need to check the information in peer-reviewed journals (Entwistle, 1995).

Much of my journalism was concerned with mainstream medicine, so I too scanned these journals, not by subscription, but through receiving press releases via AlphaGalileo, the internet press website for European science, medicine and technology, that receives science news from prominent scientific organisations. This was my first filter; others were press releases from academic journals that had press offices, such as *The Lancet*, the *BMJ* and the Royal colleges.

Over-reliance by journalists on such publications can be a danger. Scientific research is published is to expose it to critical assessment and to encourage others to replicate the findings (Karpf 1988: 111). Levi notes that clinical trials “do not deliver definite truths about a treatment’s effects – all research results are more or less uncertain.” (2001: 65)

However, this reliance by medical journalists on information delivered through peer-reviewed journals arises from the diverse and complex nature of science itself. Dorothy Nelkin (1995) calls this the “constraints of complexity”, an additional constraint (along with editorial supervision, audience assumptions and economic pressures), that is peculiar to science journalists. Journalists covering medicine and health have to assimilate and simplify vast amounts of (often) complex material, much of which, even with a qualification in science or medicine, is difficult to absorb.

“The complexity and uncertainties of scientific subject matter reinforce the tendency of journalists to rely on press releases, press conferences, and other prepackaged sources of information.” (Nelkin: 119)

I would argue that this regard for peer-reviewed medical journals still exists, even after the publication of Dr Andrew Wakefield’s discredited research, published in *The Lancet* (1998), on the supposed link between the MMR vaccine and bowel disease and autism.

For my journalism on CAM, I referred to clinical studies and comment articles in mainstream medical journals and journals specifically devoted to CAM. Karpf notes that medical journals are “notoriously unfriendly to positive studies of complementary medicine” (113), but I (and my colleagues and editors) valued their content and several of the studies published in such journals had positive findings. I also found that journals

whose remit was a specific specialism, such as *Gut* or *Pain*, proved more receptive to publish studies on CAM than the *BMJ* or *The Lancet*.

For my journalism on hypnotherapy, for instance, I found and cited several studies published in high-profile mainstream journals (Stewart and Thomas, 1995; Whorwell, Prior and Colgan, 1987; Harvey *et al*, 1989). Evidence presented in some studies, such as those published on iridology in *The Lancet* (Knipschild 1988, 1989), was so irrefutable that getting contradictory “evidence” from iridologists seemed ethically unsound.

While a trademark of good journalism is that journalists give equal weight to opposing views, the weight of scientific evidence on some issues is so strong that journalists seeking to do so create a “false balance” (debate, City University London, 25 March 2014). “Why talk to wizards?” remarked Michael Hanlon, an author and former science editor of the *Daily Mail* and a panel member, in an effort to “balance” an article. Many scientists believe that journalists should not seek opposing views on subjects, such as homeopathy. I talked to all stakeholders, but rarely gave equal weight to the evidence.

Some of this “evidence” was drawn from CAM journals, the number of which had proliferated in the late twentieth century. I was wary of their content, but I could not ignore them. The discourse was similar to established journals, and some contained double-blind placebo-controlled studies, but often the researchers, and most of the board members, were practitioners. *Alternative Medicine Review*, for instance, claims, it has the highest impact factor of any journal in the field, yet is published by a company that manufactures dietary supplements.

Shoemaker (2014) writes that sourcing is an important shaper of content and that institutional sources are more readily available to journalists than non-institutional sources, and therefore attract more media attention. To an extent this is true: I paid more attention to research from high-impact peer reviewed journals than to research published in CAM journals, which in turn shaped what received my attention and who I chose to interview.

However, while secondary sources were important in covering CAM, as a freelance journalist, fitting journalism around other professional responsibilities and working under the pressure of a deadline, I often relied on my regular contacts. Gans (2004) found that time pressures, staff crunches, and other factors result in journalists relying on such sources, particularly institutions. “Either sources or journalists can lead, but more often than not, sources do the leading.” (116).

Primary Sources

Gans writes that the relationship between sources and journalists resembles a dance, with sources seeking access to journalists and vice versa (Gans, 2004: 116). Writing about newsrooms, he maintains that while “it takes two to tango” the source-journalist relationship is more like a “tug of war” with the sources attempting to “manage” the news and putting the best light on themselves, and the journalists trying to “manage” the sources in order to extract the information they want.

I would argue that the source-journalist is more complex in science journalism, as outlined below, and different again when it came to covering CAM. The people that I interviewed for all my journalism in this field were only too willing to dance – eager and agreeable, to use Gans’ description – because they wished to promote a therapy or product, or to disprove it.

Because science is so complex, journalists have developed elaborate strategies to judge the significance and validity of news and medical information and that includes cultivating relationships with scientists whom they can turn to as “sounding boards” (Weitkamp, 2003). All journalists must develop trusted sources (Randall, 2011), but no more so than in science journalism, and especially when covering complementary and alternative medicine.

Karpf writes that journalists are “addicted” to experts (1988: 111). They rely on scientific institutions, clinicians and researchers to feed them stories and explain the complexities of biomedicine. Karpf notes that medical journalists try to protect themselves by using only certified experts and medical authorities carrying an institutional seal of approval. “Going to centralised sources saves time and covers them” (125). Kriegbaum suggested that science writers are less industrious than their other specialist colleagues, spending more time attending conferences and scanning press releases and journals and less on “foraging in laboratories” (Kriegbaum, H., 1967 in Gandy, 1982). Gandy talks of a “dependency relationship” between science journalists and their sources (106).

Yet this reliance can lead to what Levi regards as a “blind admiration for science” (75). Medical journalists have been criticised by investigative reporters, who suggest that independent journalism implies a more critical approach. Levi notes that the relationship between journalists and their sources has traditionally been closer – cosier, even – in medical reporting than in many other fields. John Crewdson, a Pulitzer prize-winning investigative reporter, wrote in a Neiman report that science journalists were “perky cheerleaders” for scientists and that they indiscriminately reported what experts

said, acting more as stenographers than journalists. “Reporters must check things out and know enough about the field to smell a rat when there is one.” (1993)

On reflection, there were times when I acted as a “perky cheerleader” when I undertook interviews with experts for features about mainstream medicine, grateful that they broke away from their clinics to return my calls. I found that the more high profile these sources were, the more willing they were to be interviewed, particularly if I was writing for a national newspaper.

Why do medical journalists, including myself, feel safe from criticism if we rely on information from medical institutions and/or big-name doctors? Why does the opinion of a consultant physician have more weight than, say, a highly experienced and qualified acupuncturist? Paramedics, such as nurses or pharmacists, however senior, are rarely, if ever, given a platform.

Ben Goldacre argues that the media often uses authority figures “as if they were priests, or politicians, or parent figures” which, he writes, is the very antithesis of what science is about.

“There is a danger with authority-figures coverage, in the absence of real evidence, because it leaves the field wide open for questionable authority figures to waltz in.” (Goldacre, 2009: 240)

A seminal study by Hall *et al* advances the argument that powerful “accredited” sources, such as government departments, legal institutions, the police and established interest groups close to government, enjoy privileged access to the media (1978: 57). News reporters, under the pressure of a deadline and with these contacts to hand, naturally call upon them. These sources have become “elite sources” and “primary definers” and in the coverage of medicine, specialist consultants and medical researchers are elite primary definers. Which sources become “primary definers” in the field of CAM is, as Hall notes and which I intend to analyse in a later section, how journalism in the field of CAM was framed.

Karpf argues that the media share the dominant beliefs about medicine – that it is objective knowledge arrived at through scientific endeavour and therefore beyond dispute (1988 p. 130). This is only partially true, and I, and most of my colleagues, interrogated medical research because we knew it was not beyond dispute. Seale is correct to say that Karpf’s account of medical dominance is slightly dated (Seale, 2002: 63), especially since the publication of a fraudulent paper in *The Lancet* on the MMR vaccine (Wakefield, 1988). Nevertheless, her work is significant in pointing out the influences on medical journalists. Indeed, the pre-eminence of the medical profession

has increased and it now has the monopoly of expertise not only in the treatment of illness, but increasingly in other areas of life, resulting in the “medicalisation” of what Dworkin refers to as “everyday unhappiness”.

“While before, a man experiencing trouble would have searched out a minister, a priest, or a rabbi to unburden himself, now he will just as often seek out a health care professional.”

(Dworkin, 2001: 12)

The Search for Credible Sources

Dunwoody and Ryan (1987) state that sources must be able to communicate, must be accessible to reporters and must seem to be at least minimally honest and reliable. “But, perhaps most important, they must be credible”. (21)

When it came to sourcing CAM, there was a cacophony of sources and credibility was my main challenge. Choosing who to choose as an “expert” is a complex process, which most journalists (including myself) learn through experience, and are given little or no guidance, as Boyce notes. (Boyce, 2006)

In the field of CAM, there were five groups of sources: the “**sceptics**” – academics and/or physicians who were conducting research or had an academic interest in the field; the “**dispassionate observers**” – academics, researchers, such as toxicologists and healthcare professionals whose patients were treated with CAM therapies; the “**believers**” – heads of CAM organisations and the practitioners they recommended; “**witnesses**” – those people who had experienced a particular therapy or therapies and who journalists refer to as “case histories” and a fifth hybrid category – the “**sceptical believers**”.

This last group were elite sources who some journalists might view as primary definers, but whom I regarded as less authoritative than the sceptics. Many were medically qualified and included heads of university centres of complementary medicine, which offered undergraduate and postgraduate degrees in CAM; members of the House of Lords Select Committee on Science and Technology, which produced a report on complementary and alternative medicine in November 2000, and heads of homoeopathic hospitals and CAM health centres.

Dunwoody and Ryan talk of the “visceral nature of credibility decisions” (21) and there was an element of truth in this in my choice of sources. They argue that “a police chief is not credible because reporters have made him or her so; instead credibility is bestowed on that individual by the bureaucratic, legitimized environment in which he or she works.” (21-22)

When it came to CAM, this was not necessarily the case; the sceptical believers worked in legitimised environments, but to me had less credibility than the sceptics or dispassionate observers, some of who worked outside universities.

Many of the believers too had credibility. Unregulated, untrained in medicine and unused to criticism, they believed in what they practised. I believe few of those I interviewed were knowingly “snake-oil merchants”, even if what they practised had little or no scientific legitimacy.

My criteria was that they had to demonstrate substantial training, belong to a credible official organisation and have no *substantial* vested interests, such as owning a chain of health clinics. While it matters little if, for instance, a homeopath has two weeks’ or two years’ training as what they are purveying is water, it does ensure some element of patient safety. However, some therapies had no umbrella organisations to offer guidance, and there has been considerable debate on cult information websites about the abusive nature of one practitioner I interviewed for *The Express*.

I built up relationships with certain academics and researchers in the field. These were “trusted” sources, on whom I relied to supply me not only with research into the efficacy and safety of each therapy, but to advise me which were the most reliable organisations to approach. I also wanted their opinions, which I needed to help form *my* views.

Boyce (2007) writes that journalists turn to expert-sources for three reasons: to provide facts, add credibility and present objectivity. The journalistic ethos, she writes, suggests that a source should be a ‘top guy (sic) in the field’ to safeguard credibility” (Conrad, 1999, p. 291 in Boyce, 2006). With this emphasis on qualifications, it necessarily follows that those expert-sources without conventional qualifications will be over-looked. There was little point in interviewing medical clinicians who opposed all CAM modalities, for such a stance demonstrated a poor knowledge of CAM and would add little to my journalism.

Ernst was a “dispassionate observer” and became one of my main credible expert sources because he was a medical clinician and was trained in several complementary therapies. He was professor of complementary medicine at Exeter University, appointed to apply scientific scrutiny to CAM therapies.

“Complementary medicine has always come and gone in waves, similar to the one we are experiencing now. Therefore, historically, you need science to establish an evidence base, because if you have that, it won’t go away. In a way, I think I am the biggest champion of complementary medicine, and all those others who are over-critical are acting to the detriment of complementary medicine in the long term.” (interview, November 2006)

Some medically-qualified practitioners, to whose opinion I would usually give weight, had bizarre explanations for how their therapies worked. Dr Peter Fisher, a consultant rheumatologist at St Bartholomew's Hospital, London, a homoeopath and research director at the (then) Royal London Homoeopathic Hospital, made an analogy between homoeopathy and a computer disc.

"The disk may be imprinted with the complete works of Shakespeare, but in material and chemical terms, it contains just vinyl and ferrous oxide, nothing more. Analysis would reveal that a homoeopathic medicine, when analysed, contains just water, ethanol (the medium in which it is diluted) and lactose (from which the pills are made) but also... "information" stored in a physical form, which is not amenable to chemical analysis...Dr Fisher's view is that homeopathic medicine gives the body new and correct information, enabling it to heal itself." (*The Which? Guide to Complementary Medicine*: 157)

This concept of the body "as being this highly integrated complex quantum sensitive thing" (interview, Dr Julian Kenyon, co-founder of the Centre for the Study of Complementary Medicine in Southampton, February 1996), lies the heart of much of the thinking behind CAM. There is no science underpinning how homeopathy works and appropriating quantum theory to explain the baffling and inexplicable does not make it any more believable.

It was the sceptical believers, in which category these two sources belonged, of whom I was most wary. Medically-qualified CAM practitioners, working in respected institutions, they wrapped a cloak of legitimacy around CAM, underpinning it with the "legitimacy" of science. Dunwoody and Ryan argue that scientists "are believable when they stay within their data and interpret those data properly. They are not to be believed when they go beyond their data or otherwise misuse them." (22)

This last criterion was what made the dispassionate observers, such as Ernst and the toxicologists at the Medical Toxicological Unit, such powerful and trusted sources. It was also why I had misgivings about the sceptical believers. *They* were the emperors, medical clinicians wearing their shiny new CAM suits, working in legitimised institutions, and favoured in the eyes of most editors.

To help discern who was a "good" source and who was to be avoided I paid attention to the views of my colleagues. As Karpf notes contacts are generously shared among journalists and "requests for an articulate cancer specialist/a radical dentist/or a pro-induction obstetrician rarely go unheeded in an office of journalists. The circulation of contacts is no accident: a contact known to you or a colleague not only saves time but is of proven credibility." (111). I also drew on what Gans refers to as "personal" sources –

friends, neighbours and people I met at parties and functions. “If these people are talking excitedly about a new trend that has not yet been reported in the national media, a potential story is in the offing.” (Gans, 2004: 127)

Sourcing CAM was hugely problematic. In the late twentieth century, there was a growing body of evidence for the efficacy of some therapies, even though there was little or no science underpinning them. Readers were using it and editors could not get enough of it. The dilemma is plainly articulated by Dr Richard Middleton, the technical manager of a herbal product company and one of my sources.

“If a journalist went to someone like xxx [a well-known sceptic], he would say that complementary medicine was absolute rubbish, but that’s not really helping the journalist because you’ve got an increasing percentage of the UK population who are turning their backs on conventional medicine and want complementary medicine. A journalist should recognise that their readers are going to buy and use herbal medicines. Just to be totally critical is not actually being helpful to the reader. What a journalist has to do is find a person, or set of people, he trusts and believes in.” (Dr Richard Middleton, interview September 2013)

The Power of the Case History

Ernst (2004) maintains that the UK media “relentlessly promote alternative medicine through the use of anecdotes”. Journalists need them to get the reader’s attention and readers like them because it helps them to identify with the subject at hand, writes Ernst. But, he adds, an anecdote on its own is “utterly meaningless” and it should be backed up by evidence.

Levi too talks of the “tyranny of the anecdote”, but says that journalists’ predilection for anecdotes is not a problem if such narrative devices are used carefully and sparingly. They should not, however, be confused with scientific evidence.

“Anecdotes breathe life into medical stories, create empathy and help the audience understand an individual patient’s situation. Although single cases may illustrate the effects of a treatment, anecdotes should never be portrayed as evidence.” (63)

The criticism by scientists of the use of anecdotes arises from a misunderstanding of the nature of journalism. Scientists aim to educate and inform, and would prefer if journalists did the same. In general, journalists do not see their role as one of “educating” readers, but rather one of informing and entertaining them. How far these two enterprises can be incorporated into one framework – journalism – is a challenge, but when it comes to writing about complementary and alternative medicine it is paramount. The case history (negative or positive) is the best way to add colour to a story about CAM.

“Speaking personally” is now core to the practices of journalism. This, Coward maintains, is “the leitmotif of today’s media” (Coward, 2013: 3). Yet, she adds, there is little about “confessional journalism” when it comes to critical dialogue, analysis, reflection and debate, either among journalists or in academia. (7)

As I outlined earlier in this dissertation, the late twentieth century witnessed the rise of the consumer and individualism. The corollary of this, as Furedi argues (2004), is the erosion of the line between private and public.

“By treating emotion and feelings as the defining feature of individual identity, the private sphere has become a legitimate area for public scrutiny.” (43)

The 1980s saw the spread of the tabloid agenda across journalism, breaking down some of the old barriers between hard and soft news, object and subjective writing. “Featurisation”, as Coward points out, (81) began to affect all newspapers, broadsheets included.

“On the one hand personal ‘soft’ subjects like health, family, emotional life and sexual relationships moved into the mainstream. On the other, more personal stories and subjective writing began to be found across newspapers generally.” (82)

Furedi and Coward focus on confessional journalism, epitomised by journalists such as John Diamond, who wrote in *The Times* about his four-year battle with throat cancer (to which he succumbed in March 2001) and Ruth Picardie, who wrote in *The Observer* under the headline “Before I say Goodbye”, about living with a terminal cancer diagnosis.

“Case histories” – the term used by journalists and journalism educators – is standard fare in features, and increasingly news, and almost a cliché. Readers want to hear about “ordinary” people, like themselves, who have experienced a particular illness/treatment/experience. These stories, whether or not the journalist intends it, are as powerful, if not more so, than evidence gleaned from experts or peer-reviewed journals, as Coward notes.

“You could even say we fetishise reality since far greater value is put in descriptions given by people who have lived through experiences than scenarios imagined in fiction, or reports based on research and canvassed opinion as in conventional feature writing.” (90)

When it came to CAM, readers wanted to know what a particular therapy felt like and whether or not the case history found it effective. The standard structure I used was description of the case history’s condition, what he or she felt about the particular therapy and whether or not it had alleviated the condition. Although I was asked to interview several case histories for my books only two were published in *Alternative*

Answers to Asthma & Allergies (Rowlands, 1999: 16 and 28) and two in *The Which? Guide* (Rowlands, 1997: 45-47).

Most were published in *The Express's* series, "Exploring Alternatives". All these were supplied by practitioners, whose names were given to me by the umbrella organisation for a specific therapy, and all the stories were positive. Academic scholarship has remarked on the positive tone of CAM coverage (Weeks and Strudsholm, 2008; Ernst, 2000), but in the explanatory article for this particular section, a "positive" case history was what editors required.

The Which? Guide asked me to find two case histories – I chose one who had had a positive experience and one whose experience had been negative. I sourced the latter through the Patients Association, a campaigning group working for improved care in health and social services. I conducted this interview, like all the other case histories, by telephone. The interview was with Patricia Moore, whose husband, Alexander, had died of cancer, aged 32. She told me that he put his trust in alternative practitioners and spent his last months undergoing therapy after therapy "chasing mirages" (*The Which? Guide*, Rowlands, 1997: 47). I had to persuade Which? Books that it was important to include it, as evidenced in my fax to my editor, in response to her queries.

Yes, this is a negative case history, but it is also a very moving one. In my career I have come across people who have had negative experiences with complementary therapies and plenty for whom nothing happened. Few, if any books give the negative side of CM...this is a small attempt to redress the balance. Even if they are well regulated, at the end of the day, some therapies are just plain nonsense and this point ought to be made (fax to Emma Johnson, 4 September, 1996)

There is, of course, a danger with this kind of journalism. Case histories may wish to proselytise about their treatments or exaggerate to please both journalist and practitioner. A desire to "entertain" (whether on the part of the journalist or interviewee) often creates a conflict between "satisfying the goal of accuracy and the goal of entertainment. The desire to entertain can sometimes be the stronger of the two, putting the truth in jeopardy" (Gilovich, 1993: 98). Scientists maintain that anecdotal evidence often fails to match up to scrutiny and may contradict the findings of clinical studies. In this way, the subjective voice is disparaged by both scientists and journalism scholars.

The inclusion of personal material is traditionally confined to national newspaper features pages, magazines and tabloid newspapers and the breaking up of newspapers into discrete sections has made this hard/soft distinction even more obvious (Aldridge,

2001). Coward argues that journalism scholars dismiss “confessional journalism” as “soft” news, as opposed to accurate, objective and impersonal “hard” news.

She likens the explosion in personal material and first-person writing to a lake fed by tributaries each one a different cultural force “from disillusionment with so-called objective journalism and its hidden voice of authority, through a growing cultural need to see the person behind the views, to the increasing preoccupation with confessing, exploring and witnessing intimate feelings and reactions to life’s dilemmas.” (ibid: 136)

In all my health journalism, I have used case histories to illustrate the reality of illness and treatment. This is what Harrington called “the journalism of everyday life” (1997: xiii). In many of these interviews, I have, as Harrington notes, a “hybrid ethical outlook” (ibid: xxiv), serving not just the audience, but the case history as well, protecting the welfare of the subject, but not omitting information that might compromise the audience’s understanding of the story.

This area of journalism is worthy of scholarship, for there is a growing tendency to use case histories not just to *illustrate* a particular illness, condition or situation, but to present it *entirely* through the prism of one person’s experience. Disturbingly, health journalists are now encouraged to write about their own strokes, migraines, infertility, depression and treatment, complementary or mainstream, they might have undergone, in a display of journalistic self-harm. Both reflect the rise of confessional journalism, and an aspect of it that ill serves the audience, omitting, as it does, clinical evidence from primary and secondary sources.

PowerPoints, Press Releases and Press Trips: a PR case study

Dorothy Nelkin asserts that scientists “ventriloquate” through the media to those who control the funds (Nelkin, 1995: 124). Both journalists and academics have provided evidence for the increasing role of public relations in science journalism over the last 20 years (Williams and Clifford, 2009; Hargreaves, 2003; Davies, 2008; Davis in Cottle, 2003). It has come increasingly important as an agenda setter, providing journalists with story ideas and a “jumping-off” point for further research (Williams and Clifford, 2009).

In the late twentieth century CAM organisations were extraordinary successful in this, enhancing their prestige and credibility and influencing public policy to such an extent that CAM therapies were being taken seriously by healthcare professionals and sometimes “integrated” into mainstream medicine (Stone and Matthews, 1996).

Nelkin notes that many journalists are cynical about press releases, feel manipulated by public relations companies and regard press conferences and events as “a source of free

meals, free booze” (1995: 121). Karpf points out that food and commodities companies, attempting to exploit or challenge a health craze, “sponsor” academics to make out a case for their product (1988: 119). Journalists object to being “used” by sources, and media events have been criticised by non-journalists as “pseudo-events”, a term first used by Daniel Boorstin (1964) to describe media events that are pre-scheduled and should therefore not be treated as “news”.

Gans argues that a taboo on these pseudo events would limit journalists to covering breaking news and that such events are “staged for the physically present audience” which acts as a foil for the “absentee audience”. He also states such a taboo would disadvantage sources that lack other means to reach the media (2004: 123).

In CAM, there were no “breakthroughs” and few of the umbrella organisations issued press releases. It was left to the manufacturers of herbal and nutritional supplements to stage events, conferences and issue press releases, as they were the ones who were launching new products.

Journalists filter events they choose to attend and I rejected those that came from companies whose products were unsupported by evidence. Nevertheless, I attended functions where I thought I might meet fresh sources with new stories, even though I knew I would not be writing about the specific product that was being launched.

One of the leading manufacturers of phytomedicine was the German company, Lichtwer Pharma, which manufactured a range of standardised herbal supplements. Founded in 1981, it was one of the few companies at the time that undertook scientific research into its products. Its original supplement was Kwai garlic, sold as a licensed medicine in Germany, but the foundation of its success was St John’s Wort extract.

By the mid 1990s, over 30 clinical trials, many funded by Lichtwer Pharma, had been conducted on extracts of the plant, increasing sales of the company’s St John’s Wort extract from \$23million in 1994 to \$66m in 1996 (Müller, 2005; Nash and Cray, 1997). While the use of St John’s Wort had been steadily increasing in Germany since the mid 1980s, it was a meta-analysis in the *BMJ* demonstrating that extract of the plant was more effective than placebo for the treatment of mild to moderate depression (Linde *et al*, 1996), that introduced it (or re-introduced it as its medicinal use stretched back Ancient Greece) to the West. The study was immediately picked up by journalists and created a “media storm”, turning St John’s Wort, almost overnight, into “the world’s first herbal blockbuster”(Wahlberg, 2008: 91).

Lichtwer Pharma was successful for three reasons: it demonstrated the efficacy of its

products with scientific research; it had a knowledgeable, plausible and “journalist-friendly” technical manager, who attended all the company’s press events, and it had press relations that were unusually slick for the time. Hargreaves notes that while PR professionals are hired to serve the interests of the company that employs them, they can only do this effectively if they are trusted and this “requires plain-dealing and integrity.” (Hargreaves, 2003: 204)

While the company employed a PR company, Dr Richard Middleton was used to provide that integrity. He had a BSc degree in pharmacy, a PhD in medicinal chemistry and microbiology, and had worked as a lecturer in medicinal chemistry and cancer research. Though he was Lichtwer Pharma’s technical manager, the company used him to add scientific gravity to its products. Dr Middleton was a source of mine at the time, and I interviewed him for this dissertation. He said that while his “first love” was research, he enjoyed the company of journalists – and importantly for Lichtwer Pharma, they enjoyed his company.

“I like talking to journalists because on the whole they are pretty intelligent people and you can have some good conversations with them.” (interview, 16 September 2013)

There is an inherent danger in liaising too closely with sources, particularly those whose company you enjoy, as Karpf notes.

“The longer and closer they associate with their official sources, the more they tend to see the world through the sources’ eyes. The sources’ world view prevails merely by dint of prolonged contact. And you get to like the guys.” (1988: 125)

Lichtwer Pharma courted journalists shamelessly. It sponsored evening seminars, mounted by the Guild of Health Writers, and its members were regularly invited to the media events it held. It is revealing to examine how this company operated and worked with the media and I will do so through an examination of one press conference and one press trip.

In December 2000, I was invited by Lichtwer Pharma to “Christmas Lunch with the Naked Chef” (Jamie Oliver) at a West End restaurant. Speakers included the chairman of the European Herbal Practitioners Association, a senior lecturer in human nutrition at University of Reading, a professor of human psychopharmacology at the Medical Research Centre at the University of Surrey, plus health psychologists and pharmacists – and, as master of ceremonies, Dr Middleton. Enticingly, the invitation said “over 50 health editors and writers of national titles are attending the lunch and you will have the opportunity to quiz experts about their latest research and new trials that are underway.”

Two of the five goals that Schlesinger and Tumber (1994) state an ideal source would have when dealing with the media are a well-defined message to communicate, capable of satisfying news values, and the identification both of an optimal location for placing that particular message and the target audience. Lichtwer Pharma and its PR company were well aware of both.

Researchers analysing science reporting have shown that a greater number of sources, such as scientists with a specific and relevant area of interest, research studies, and health professionals, lend greater credibility to news stories than do fewer sources, and sources that included celebrities or non-health-related sources (Ramsey, 1999; Hatley-Major and Coleman, 2006, in Coleman, Thorson and Wilkins, 2011). There is also evidence that competent or expert sources, without a vested interest in the information, are more credible (Salwen, 1992, in Coleman, Thorson and Wilkins, 2011).

The sources at events such as the one described above, were relevant, available and providers of not just information, but ideas. Dunwoody and Ryan (1987) write that scientists are “credible” when they stay within, and are focused on, their area of research expertise and are often allied to universities. Many were, but nevertheless before attending an event such as this, I would review research on possible adverse interactions with drugs, so that I could challenge them. These events provided me with fresh ideas to pitch to my commissioning editors, the opportunity to explore wider trends in the field, meet colleagues, deepen relationships with contacts and make new ones.

Lichtwer Pharma sometimes eschewed presentations in favour of building relationships with selected journalists. It offered regular weekend press trips to Cork, Ireland, home of its St John’s Wort manufacturing plant. Most journalists who covered CAM, myself included, were invited on one trip.

The company’s aim was to give the journalists an enjoyable time, so that they would feel positively towards its products. Presentations took place on arrival, but they were usually just an hour squeezed between lunches and dinners at expensive restaurants, tours of herb gardens and sightseeing. The company took the rare decision to invite the journalists’ partners, some of whom were journalists as well.

Dr Middleton knew that journalists enjoy each other’s company. Towards the end of one dinner, he placed a bottle of Irish whiskey on each table plus several packets of Cynara artichoke pills, which the company claimed enabled the liver to synthesise alcohol and rich food. He invited us to partake liberally of both. There were few hangovers the next morning.

“I think those press trips to Cork were absolutely fantastic – best thing we’ve ever done. We took partners – husbands, wives, girlfriends, boyfriends. It made it twice as expensive for the company, but it was well worth it. It was all about building up relationships. The actual formal lecturing was minimal – and that was deliberate.” (Dr Richard Middleton, interview September 2013)

Like my colleagues, I felt no pressure to accept an invitation unless I felt it would result in a story. Nevertheless, luxury was a lure and twinned with a possible story, hard to resist. I attended an overnight stay at the two Michelin star restaurant and hotel, Le Manoir Aux Quat’ Saisons, with my partner (an increasingly common ploy used by PRs) for the unveiling of a new probiotic⁸ supplement. Yet, despite the magnificent dinner, cooked by chef Raymond Blanc, and a consultant gastroenterologist put up by the PR company to answer our questions, many of us had our doubts about swallowing bacteria, however “friendly” that could interact with the body’s own bacteria. I never wrote it up.

Press events offered in the field of CAM were often one-or two-day trips, which were enjoyable but involved giving up two or three days’ paid work. A typical itinerary – a press trip to Zurich to tour the fields and factory of the herbal supplement manufacturer, Bioforce – can be found in the appendices.

Often editors, reacting to the news agenda, would commission me to expand on stories in the news. For instance, I was commissioned by my editor at the *Daily Telegraph* to write a feature for the ‘Does it Work’ column on pendants worn by celebrities to protect them from “harmful” electromagnetic rays. Cherie Booth sported a BioElectric Shield, as did Hillary Clinton. I felt there was little or no evidence underpinning such talismans (which is what they were), but also pleased to be given the opportunity to point this out to readers, who otherwise might have been persuaded to part with £119 for the silver and brass pendant. I include the feature in Volume 2 (“Charms can calm but don’t risk those Rays’, *Daily Telegraph*, 20 August, 2000)

Julia Hobsbawn notes that journalism and PR, both central to the “architecture” of public information are locked in a “rancid” relationship that make things worse, not better, for their audiences (Hobsbawn, 2006). In the field of complementary and alternative medicine, particularly herbal supplements, journalists like myself relied on public relations to keep us supplied with ideas. I did not experience my relationship with PRs as “rancid”; the events they mounted provided opportunities to get fresh ideas, interrogate any evidence and meet colleagues. Nevertheless, at times I felt overwhelmed by press

⁸ Probiotics are bacteria, packaged in supplements or added to yoghurt, that are believed to restore gut bacteria which has been disrupted

releases and products (boxes of supplements would arrive regularly at home), which, far from creating a similar “world view”, produced the opposite effect. There was a tension, for, as Angela Phillips notes (in Franklin and Carson, 2011: 57), if journalism is to mean anything, it must be rooted in truth telling.

Chapter 6: The Framing of CAM

Over the last 40 years an impressive body of literature has built up around the notion of framing, in fields as diverse as management and organisational studies, psychology, sociology and media studies. One of the earliest scholars in this field, Gregory Bateson, argued that that “communication only gets meaning in its context and by the way the message is being constructed or framed” (Bateson, 1955) and since then scholars have contributed greatly to our understanding of how the media attempts to frame reality. In this section I will endeavour to contextualise my work on CAM within some of this research. I will also refer to the academic literature on news values and how journalism can be distorted by editorial constraints and pressures.

Scholars in the field generally look at how journalists frame news events, but as Goldacre points out, science “works very badly as a news story...because it does not move ahead in sudden epoch-making breakthroughs” (Goldacre, 2009: 236). It is, he argues, much more suited to the features pages, where in the 1990s and early 2000s, it found a comfortable home in the health sections of magazines and national newspapers. Nevertheless, much of the scholarly work based on an examination of news and its production, remains relevant to the reporting of CAM.

Re-visiting Framing Theory

The purpose of news and journalism is not just to tell us what we want to know, but what we “need to know, and should know” (Tuchman, 1978: 1). This was what drove much of the coverage of CAM at the time. When I was reporting CAM, neither the medical profession nor the public knew much about complementary and alternative therapies (Fulder, 1996) and much of my journalism in this field, and that of other journalists, was didactic – to explain to audiences what they *should* know about CAM, its multiplicity of therapies, its unfamiliar terminology, the strange explanations for how they “worked”. As Nelkin notes (1995) by selecting stories out of a myriad of events and issues, science journalists define certain subjects as newsworthy.

Entman, in his seminal paper on framing, argues that the concept of framing “consistently offers a way to describe the power of a communicating text” (1993:51). Frames illuminate how influence over human consciousness is exerted by the transfer of information from one location, such as a speech or a news report, to that of consciousness.

“Framing essentially involves selection and salience. To frame is to select some aspects of a perceived reality and make them more salient in a communicating text, in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or

treatment recommendation for the item described.” (ibid: 52, italics in text)

Entman states that frames *define problems*, which he writes are usually measured in terms of common cultural values; *diagnose causes*, that is, identify the forces creating the problem; *make moral judgments* and *suggest remedies* – i.e. offer and justify treatments for the problems and predict their likely effects.

The “salience”, he writes, makes “a piece of information more noticeable, meaningful or memorable to audiences” and while it is achieved by highlighting certain aspects (in the case of CAM, for instance, “holism” and “natural”) it simultaneously directs audiences away from what it omits (such as potential harm or lack of regulation) (Kahneman and Tversky, 1984).

Gitlin says that frames “are principles of selection, emphasis, and presentation composed of little tacit theories about what exists, what happens, and what matters” (1980: 6) enabling journalists to process large amounts of information quickly and routinely, relaying it to their audiences efficiently.

In most studies, researchers found a wide variety of devices were available to signal the presence of a frame, such as “keywords” (Entman, 1993). Journalists make “lexical choices”, choosing which quotes, words and phrases to use, many of which are supplied by their sources and can be employed as “catchphrases” (Pan and Kosicki, 1993). Important too are non-textual elements, such as pictures and graphs. Tankard (2008) identifies 11 framing mechanisms, of which two are visual – photographs and statistics and charts and graphs. So the way in which journalists covered CAM and the way this journalism was “packaged” visually and typographically had a powerful impact on the beliefs of the audience. As Tuchman writes, the news media have the power “to shape news and consumers’ opinions on topics about which they are ignorant.” (1978: 3)

Arguably, the most powerful frame that editors and journalists covering CAM appropriated was that of science itself. By commissioning health journalists such as myself to report on it, by publishing it in the health pages and by giving it a coherence and importance it (arguably) neither had nor deserved, this journalism helped shape a public definition of what CAM was.

Hall and his colleagues talked about creating “maps of meaning” – a cultural consensus where society maintains the same perspective on events (Hall *et al*, 1980). He was referring to news events, such as a specific crime, but CAM was framed, quite specifically, I will argue, “into frameworks of meaning and interpretation” and the media, including myself, offered the audience “powerful interpretations of how to understand these

events.” (1980: 57). The media is “cued in” to specific new topics by “regular and reliable institutional sources”. These sources become primary definers of a particular topic.

“This interpretation then ‘commands the field in all subsequent treatment and sets the terms of reference within which all further coverage or debate takes place.’ (1980: 58)

The primary definer in the coverage of CAM was the British Medical Association. The BMA’s 1993 report, *Complementary Medicine: New Approaches to Good Practice*, had a markedly more conciliatory tone to its 1986 report, *Alternative Therapy*. Its view was that an increasing number of patients were seeking help from CAM practitioners, there was a growing interest among general practitioners and that there was a need for some regulation of therapies and “better *information* in the use and practice of non-conventional therapies, which is not presently met.” (BMA, 1993: 36)

This 173-page book, published by *the* primary definer in the field of health journalism, had a profound impact on the media. It expunged any notion that complementary and alternative therapies were “fringe” modalities peddled solely by snake-oil merchants to the rich, gullible or vulnerable, but a diverse assortment of treatments through which consumers could achieve “total” health, now endorsed by Britain’s leading medical institution. Scholars examining media coverage of CAM note the increase in coverage in the 1990s (Weeks and Strudsholm, 2008; Bubela *et al*, 2007).

Narrative Structures: Telling the Story of CAM

How a piece of journalism is structured – its narrative armature – is closely linked to how it is framed. The structural template imposed by the traditional “inverted pyramid” news structure, an important framing device cited by some scholars (Pan and Kosicki, 1993; Hall *et al*, 1980), is absent from the general coverage of CAM. However, to deliver the unfolding story of CAM we used two structures familiar to audiences. The first was the classic “explanatory” story, which outlined how a particular therapy worked and the second was the “reality check” template, which takes a closer look at the veracity of information or statements.

These terms were coined by The US Project for Excellence in Journalism, run by the Columbia University Graduate School of Journalism and funded by the Pew Foundation. In 1998 it monitored three national and four local or regional newspapers over two months and identified 13 possible narrative devices that were used to deliver news stories. Three narrative frames – “conflict”, “winners and losers” and “revealing wrongdoing” – accounted for 30% of all stories. Three more – “story”, “ongoing” and “trends” – which they describe as “explanatory”, together accounted for 12% of stories. This story-telling framework explains how something works, its history, and places it in

the context of an ongoing trend. CAM fitted into this explanatory narrative structure perfectly, and was one that was familiar to audiences.

“The topics of health and medicine and of science and technology lent themselves to frames of explanation (process, ongoing trends or historical outlook). Journalists used these frames 44% of the time for health and medicine stories. That is three times as often as their use overall. Journalists used these frames 39% of the time for stories about science and technology.” (online, 13 July, 1998)

This template was used across the media to explain individual therapies to a CAM-hungry audience. This structure is frequently used by science journalists, as Nelkin notes, to simplify complex information and introduce background material (1995: 117).

It was refined even further into what I shall call an “explanatory alphabet” narrative structure, a device designed to simplify complex new modalities and which was used frequently in features and books published at the time.

This was the structure I was asked to use for *The Which? Guide, for Alternative Answers to Asthma & Allergies* and the ‘Exploring Alternatives’ series in *The Express*. It was used in the A-Z series of Alternative Health, published during February and March 1996 in the weekend *Style* section of *The Independent on Sunday*; the four-part A-Z of Chinese Medicine, published in *The Sunday Times* colour supplement⁹ and the A-Z Guide to Complementary Medicine, published in *The Times* across six Saturdays from 7 February to 14 March 1998. There was a similar structure for Dorling Kindersley’s *Encyclopedia of Complementary Medicine* (1997), *The Complete Guide to Integrated Medicine* (2000) and *The Hamlyn Encyclopedia of Complementary Health* (1996).

The structure was the same: the history of the particular therapy; what happens during treatment; whether it works; what conditions respond best; how to find a practitioner and cost and length of treatment. A case history or endorsement from a celebrity might be included and, almost as an addendum, there would be a small “warning” box-out.

My work for the *Daily Telegraph*’s “Does it Work?” column fitted into the “reality check” structure, which was useful for critically examining the efficacy of specific supplements. As audiences became more familiar with CAM, it was used more frequently to examine efficacy in general and the lack of statutory regulation (Brooker, E. ‘Quackbusters Under Siege’, *Independent on Sunday*, 24 November 1996; Toynbee, P. ‘Quackery and superstition – available soon on the NHS’, *The Guardian*, 8 January, 2008).

By giving it prominence, and mainly using an explanatory narrative template, the media

⁹ *The Sunday Times* cannot provide publication dates for this series

articulated an important a body of knowledge that their educated, middle-class readers needed to know in order to help them take control of their own health. The message, expressed in the standfirst of *Alternative Answers to Asthma & Allergies* (Rowlands, 1999: 80) was that while complementary and alternative therapies were once dismissed as “fringe”, now increasing numbers of people were turning to them and the medical community supported them. This misguided certainty, that CAM was being embraced by Britain’s medical establishment, was evidenced by *The Times’* introduction to Part 1 of its ‘A-Z Guide to Complementary Medicine’, written Dr George Lewith, founder of The Centre for the Study of Complementary Medicine, Southampton.

“It looks as though the medical community is heading towards integration, in which there are no boundaries, and no such words as conventional, alternative and complementary.”
(*The Times*, 7 February 1998)

Creating CAM Frames

Journalists used a variety of frames in their coverage of CAM, some prominent, others more muted. Melded together, these frames reinforced the growing distaste for biomedicine and created an alternative that perfectly suited the time – individualistic, consumer-driven and idealised, an antidote to a controlling medical establishment.

Wiles and Rosenberg (2001), in their analysis of 20 British health and lifestyle magazines, postulate that CAM was framed in three ways: as “a pragmatic medical tool kit” to alleviate symptoms and potentially cure illness, as a form of “healthy living” and as alternative or natural lifestyle that radicalises and empowers the aware citizens of a consumer society. All these are subsumed under the frames discussed below, which were the main ones utilised at the time.

The Three Fallacies Frame: Natural, Traditional and Safe

The major frame given to CAM was that it was “natural” – and therefore harmless – and had its roots embedded deep in history. This frame is mentioned in most of the literature dealing with representations of CAM (Barker Bausell, 2007; Coward, 1989; Buckman and Sabbagh, 1993; Rowlands, 1997, 1999; Shapiro, 2008; Singh and Ernst, 2008). Coward argues that “nature” was probably the most important concept in the alternative health movement.

“To claim that a therapy, medicine or food is ‘natural’ is to validate it instantly. ‘Alternative’ and ‘natural’ have become interchangeable concepts even if many of the alternative practitioners don’t make a particular thing of being natural.” (Coward, 1989: 150)

The criteria for “naturalness”, Coward argues, are three-fold – an absence of technology in either the production of the medicines or treatment of patients, patient safety and working with “natural” forces in the body. Left to its own devices, nature is “gentle, kind, positive and always beneficial...never degenerative or corrupting.” (Coward, 1989: 22)

To lead a “natural” lifestyle was to be “virtuous” and Coward postulates that to be natural permeates contemporary Western society – eating ‘naturally’ and living a “natural” lifestyle. This yearning for “natural” living is prominent in Western culture. Gamson and Modigliani (1989) argue that while American culture lauds technology and the benefits that flow from it, it also contains a counter theme that is sceptical of, or even hostile to technology. Of course, the idea that nature is benign is a fantasy, as Coward points out, as also I did in *The Which? Guide* (1997: 44) and as scholars examining the efficacy of CAM have done (Ernst, Pittler and Wider, 2006; Singh and Ernst, 2008).

If CAM is invariably framed as “natural”, then this laid the groundwork for another major frame – that of being “traditional” or even “ancient” – or even better still, Oriental. The fact that a therapy may have been devised centuries ago clearly does not mean it is effective (*The Which? Guide*: 45), yet the *amount* of coverage devoted to the history of each therapy, references to ancient tomes, arcane practices and exotic terminology (ibid: 101-102; 106-107; 153-155; Rowlands, 1999: 112, 116, 210) provided a significant frame for this aspect of CAM that complemented the “natural” frame. As Coward notes, few, if any therapies, sold themselves on being brand new.

If a therapy had no ancient roots, then a “powerful founding master”, who rapidly acquired that status of a guru, is frequently cited, such as Samuel Hahnemann (homeopathy); David Daniel Palmer (chiropractic); Dr George Goodheart (kinesiology) and Rudolf Steiner (anthroposophical medicine).

While some traditional medicine has merits (for instance, the use of maggots for wound healing) Singh and Ernst correctly assert that “traditional” is merely a useful quality for many CAM practitioners “because it means the placebo effect is reinforced by a dose of nostalgia”. (2008: 223)

Karpf notes that most journalists stressed the “complementarity” of CAM with conventional treatments. At its softest edge, she says, it could be depicted as “benign support, helping a patient’s recovering while the doctors got on with the real curing” (Karpf: 179). This strengthens the natural/harmless frame, reinforced by the second major frame – that of holism.

The Blame Game Frame: Holism and Myth of Total Health

Overarching the “natural” “safe” and “ancient” frames was a moral one that laid responsibility for “total health” on the individual. Moving responsibility for one’s health from doctor to patient feeds well into Wiles and Rosenberg’s notion of “a pragmatic medical tool kit” (2001) full of health-promoting products and one that empowers consumers to take control of their own health. It offers therapeutic possibilities beyond the realm of mainstream medicine and hope when none is offered by the medical profession.

CAM practitioners maintain that health is a natural state and that it is within the power of everyone to achieve it – *if* they exert enough self-control. If someone failed to get better, then it may be because they did not have the right “attitude” to their illness. This is well illustrated in an interview with a practitioner, which I conducted for the *Daily Telegraph*.

“...practitioners say that anthroposophical medicine is a package and that its potency lies just as much in changing the attitude of the patients as in the medicines themselves. ‘The approach that we practise enables people to take charge again, so it is not passive,’ says Dr Frank Mulder, a family practitioner and anthroposophical doctor at Park Attwood.”

(Rowlands, 1 August, 2000)

Others went further, as the example below demonstrates, which is taken from the transcript of an interview with another practitioner, which I conducted for the same feature but did not include in article.

“One of the potent causes of spontaneous resolution of cancer is that people change their lives completely. They take it upon themselves to live life differently. So they stop lining their nest, which in spiritual terms is unrecognisable in value and they change their lives. Cancer can remit.” (Dr David McGavin, a homeopath and practitioner in anthroposophical medicine)

CAM therapists work *with* their clients to achieve this goal of total health, tailoring treatments to the *whole* individual, the inference being (sometimes rightly) that doctors treat diseases and ailments that affect specific parts of the body, and not the whole person. In CAM, mind, body and spirit are intertwined and the therapies kick-start the body’s healing processes, restoring it to health, balance and harmony. The patient/client takes an active part in his or her healing.

Yet, as Karpf notes, holism rarely extended beyond the body. The patient’s relationships, environment and social world are almost entirely absent from any ‘treatment’ regime. Stressful “life-events”, which most practitioners believe could be tackled with diet and

CAM therapies, are rarely linked to class, ethnicity, poverty or gender (Karpf: 179).

The corollary of this “moral” frame, as Coward points out, is that a well person is a *good* person. A well person, she says, “expresses a morality, an attitude” and a sick body, “is a sign of something mentally or spiritually wrong.” (Coward, 1989: 88). The imposition of this guilt matters, particularly for those with little hope of recovery. For *The Which? Guide*, as I mentioned earlier, I interviewed Patricia Moore, whose husband, Alexander, died from testicular cancer in 1993. One of Coward’s “victims”, he spent his last months visiting therapist after therapist in a fruitless search for a “cure”.

“These people tell you it’s all your own fault. He wasn’t a bad man, he hadn’t done anything wrong. If they had told him to stay at home and maximise his time with his children and me and to enjoy the quality of every day as a special day that would have been a wonderful thing.” (transcript, interview with Patricia Moore, 1996)

The Baby Boomers’ Frame: Boutique Religion

John Diamond made the interesting point that CAM was at its most popular at the height of Thatcherism and fitted perfectly into the Thatcherite cult of the individual.

“It was where the fading hippiedom of the early Seventies was able to meet the new materialism of the Thatcherites head-on. Alternative medicine, like Thatcherism, tells us that our personal well-being is entirely in our own hands, that we can all have anything we want – perfect health, freedom from anxiety – if we want it *enough* and are willing to take the steps to make the thing happen.” (Diamond, 2001: 11)

But it was not just “fading hippiedom” melding with individualism that accounted for the popularity of CAM. Consumers longed for something else and this was provided by the third frame, rarely mentioned overtly, but there nevertheless – that of spirituality and religion. Michael McIntyre, who was head of the Herbal Practitioners Alliance when I interviewed him in 1996, articulated the prevailing mood.

“The public wants a change of belief system. When you go to a herbalist, you’re not only getting herbal remedies but you’re actually getting somebody who believes that the vital force or *qi* actually has the power to heal. It allows people to have a different belief system from the one that doctors have – here you are, have an antibiotic and out you go.”
(transcript of interview, 1996)

There is body of research examining religion, spirituality and health and a number of studies have produced findings that shed light on the links between the three. In a study comparing “baby boomers” (defined in this study as those born between 1947 and 1963) and the “cold war” cohorts – their parents’ generation – Jean-Anne Sutherland and her colleagues (2003) replicated the finding of other scholars – that for baby boomers,

increased spirituality was “significantly related to increased positive health perceptions”.

A total of 1,200 respondents were randomly contacted for telephone interviews and 597 completed the questionnaire. While the “cold war” cohort continued to practice their religion as they did in the 1950s – in church, synagogue or wherever – the younger cohort sought a “more experiential and individual spirituality” and participated more in alternative health practices.

A combination of the anti-establishment counterculture movement, political activism and a rejection of institutionalised beliefs led to “paradigm shifts in the meanings associated with spirituality for the baby boomers, who sought a more individualistic spirituality combining elements of eastern religion, meditation, native American practices, and often, drugs.” (Roof, 1993, Ellwood 1994 in Sutherland: 320)

Dworkin argues that CAM benefits from the decline of two institutions – organised religion and the medical profession – in which people traditionally found solace from their everyday distress. At a time when signs of unhappiness, such as minor depression and anxiety, are medicalised, CAM, with its promise of “wholeness” “wellness” and “inner peace” appears seductive.

“For secular people who distrust organized religion but who also dislike the ultra rational approach to mental health found in allopathic medicine (including the heavy reliance on psychoactive medication), alternative medicine is an excellent compromise.” (Dworkin, 2001:13)

CAM has the trappings of both religion and science, as Dworkin notes, with consumers confusing these physical modalities with medicine, and practitioners often using the same mechanisms as medicine – pill-taking, use of needles and manual pressure. It lies on the continuum between science and religion and some, such as healing touch, rely entirely on faith. In this way, writes Dworkin, patients collude with therapists who maintain that their illness has a spiritual significance – even a cause.

This unquestioning belief in the power of a particular therapy (and therapist) and the inability to scrutinise and question its foundations has parallels with cults, as Ernst notes in an entry in his blog (3 July, 2013). CAM has many of the characteristics that define a cult – unquestioning belief among its followers, a charismatic leader (invariably male) immune to any form of criticism, a sense of elitism among followers and a drive to recruit more followers.

To journalists, it quickly became heresy to question some of the more bizarre explanations for how some practices “worked”. Its clients, whom we interviewed, found

these therapies beneficial and a growing body of research seemed to demonstrate their efficacy. Many journalists eluded responsibility for supporting or overtly criticising CAM by writing vague phrases, such as “practitioners claim” and “research shows” and including a “warning” sidebar.

CAM’s Counter-Frame

The frames I have discussed were laid on a strong foundation. Nelkin argues public acceptance of science is based on expectations of effective new therapies, a view perpetuated in the media through their focus on short-term implications. The quest for drama, breakthroughs or “outrageous incidents” precludes the nuances of science and medicine (Nelkin, 1995: 162). These unrealistic expectations make science and medicine “vulnerable” when it fails to deliver, and can influence consumer behaviour, “especially if alternative products are available.” (Nelkin, 1995: 70)

CAM was that alternative product, using the same symbols as medicine (needles, pills, touch), but inviting consumers to locate their illness in their individual self and to be treated by someone who “personalised” their condition, transforming it from a biomechanical failure to something that they could control.

Nowhere is media criticism of medicine and the medical profession more starkly illustrated than in the coverage of the discovery at the Alder Hey Hospital Royal Liverpool Children’s NHS Trust of samples collected from 850 children between 1988 and 1996. For the media, this was the medical profession at its most paternalistic and inhumane, and medicine at its most raw – the bodies of babies stripped of their tissues and organs, without the consent of their parents, and stored in jars in a basement.

The reason I have chosen to cite this event is that it illustrates the gulf in understanding between public and the medical professional, particularly about ownership and control of the body. To examine the media coverage would take far more space than I am allowed in this dissertation, so I shall refer to a chapter, entitled ‘Representations and Reality’ by Raymond Tallis. In his analysis of Alder Hey, he talks of a “culture of contempt” towards medicine in the media and the “hounding” of the medical profession following the discovery of the stockpiled organs (Tallis, 2004: 190-200).

Organ collection, under the 1961 Human Tissue Act, was not unusual. There was no legal obligation to obtain consent from the family for a post-mortem, though most pathologists refused to undertake an autopsy without parental consent (Bennett, 2001). Tallis writes that autopsies are “a fundamental part of good medical practice” (189) and the media coverage resulted in a reduction in autopsies, a “catastrophic” collapse in

recruitment to paediatric pathology, a fall in the donation of organs and the passing of the “punitive” and “opaque” Human Tissue Act (2004), following the highly critical Alder Hey report in 2002. The media outrage “suborned the deep and unbearable emotions of bereaved parents to the ephemeral purpose of selling daily papers.” (Tallis: 191)

Dewar and Boddington write that the Alder Hey report and the immediate media response to it “dramatised a shift from one set of monolithic assumptions to another, moving from a medical paternalism to an interpretation of patient and public wishes, itself determined on the public’s behalf by an inquiry team and politicians.” (2004: 267-268). Alder Hey exposed the gulf in understanding between patients and doctors, which the media, and later the report, articulated. For doctors, the organs and tissues were just that – with no trace of the human being from whom they had been taken; to the parents they were imbued with the personalities of their children (Dewar and Boddington, 2004).

The fact that the media reacted so strongly to Alder Hey has roots in traditional news values. Most journalists have probably never heard of Johan Galtung and Mari Ruge, but nevertheless adhere more or less to the 12 criteria they regarded as essential for an event to become a news story (Galtung and Ruge, 1965). Number 12 is “reference to something negative”. Tallis laments that there is a preference for bad news over good, but all journalists know bad news trumps good news on most days and this is borne out by scholarly research (Bartlett, Sterne and Egger, 2002).

In the coverage of Alder Hey, the media used myths and stereotypes. Dewar and Boddington write that media coverage played on two powerful myths: first, the image of the “mad and bad scientist” greedily accumulating thousands of body parts, and secondly, the fantasy that any trace of human sentience remains in the dead, or parts of the dead. There were echoes of grave robbing and body snatching (rife in Liverpool a century earlier) and images of the grubby Victorian basement in Myrtle Street where the body parts were stored.

Seale writes that health journalists use “scapegoats, stereotypes, heroes, fools, victims and villains”, wrapped into stock storylines, in their coverage, in much the same way as the author of a children’s book (2002: 35). Villains, he writes, may take the form (among other things) of “wicked or incompetent doctors”, which was how Professor Dick van Velzen, the pathologist who systematically ordered the stripping and retention of tissues and organs, was framed. Seale argues that these stock storylines and characters have parallels with fairy stories and pantomime shows. The vulnerability and helplessness of “victims” is emphasised, as is the inability of people to control any threat. Set against these ogre stereotypes are the “helper-heroes” which Seale argues, may take the form of

“doctors or research scientists bearing magical cures, nurses behaving like angels, or fitness gurus pointing the way to beauty.” (ibid: 29)

After Alder Hey, it was clear that the audience wanted more of the angels than the ogres, drama that entertained by generating feelings of security and pleasure rather than anxiety or fear.

What Editors Wanted

Experienced freelance journalists understand the frames unconsciously set by editors and automatically know the “tone”. Gitlin analysed a background piece by Fred Powledge of the *New York Times* published on 15 March 1965 on the rise of the student left.

“Frames, angles, assumptions about what is salient and what is not, all flowed through the Times bureaucracy with both subtlety and persistence; the newsroom was soaked in them.

‘When this kind of communication is done by smart people,’ says Powledge, ‘it’s never done in so many words.’ (1980: 40)

And so it was with my journalism in CAM. I knew the *Daily Telegraph* would accept more criticism of CAM than *The Express*. I also knew that Marshall Publishing was sympathetic towards CAM and the book was written for a consumer audience and expressed in language that would be easy to translate into other languages. Most of the printed media, as outlined earlier in this dissertation, gave a positive portrayal of CAM and editors were sometimes reluctant to accept negative reporting, as demonstrated by this email to my editor at the *Daily Telegraph*.

Dear Jane,

Got your message and take the point. I’ve rejigged the piece to make it a bit more positive and included a bit at the end about clinical trials. Most of these have been conducted on animals but there are two on humans, both for spirulina... Klamath Lake blue green algae has come in for a lot of criticism so important to flag that up. (personal communication to Jane Taylor, *Daily Telegraph*, 2 October 1998)

The Consumers Association struggled to find a frame but in the end, I realised, it was basically sympathetic towards CAM. My editor failed to include a 2,000-word section I wrote on the placebo response, despite my strong argument that this was the most likely explanation for the efficacy of many therapies. Paragraphs, such as the one below, were not included.

“The main objection to complementary medicine from mainstream practitioners is that there is little scientific evidence to back up its claims. There is a huge body of anecdotal evidence – most people have a friend or a friend of a friend who wouldn’t do without their reflexologist, acupuncturist or healer. But on paper, not a lot of it works, and if it does

work there is no science to explain its success.” (Rowlands, 1999, original transcript)

The extensive comments faxed to me from my editor on the chapters I submitted have faded with time, but I retained electronic copies of my replies, from which it is not difficult to work out the nature of the comments. I have included some these in the appendices. This example demonstrates that my editors were querying any negative comments on CAM.

“I’m trying to be even handed. All I’ve done...is not to give CM a glowing report, as do 99.9% of books in Britain. In parts, I have bent over backwards to give it a good write-up. When editing bear in mind that the science behind many of the therapies is thin, that much of the benefit that people get is probably the placebo response and many therapists, trained or otherwise, make a very good living.” (fax to Emma Johnson, 2 September 1996)

How the reporting of CAM differed from that of mainstream medicine

The coverage of CAM differed in many ways from that of mainstream medicine. Occasionally I chose to undergo a therapy to enable me to explain it better. Was acupuncture painful? How would a traditionally-trained practitioners of Chinese medicine diagnose me and would a brew of Chinese herbs be unpalatable? Case histories were not necessarily used; they were essential for a story about conventional medical treatments and often formed the narrative thread. A feature on a particular therapy has a specific narrative structure, as has been described, which differed from that of a general health feature.

However, the major difference was in sourcing. The sources I use to cover disease, and its treatment, are clinicians, scientific researchers and the heads of health charities or pressure groups. They often disagree on their approach to treatment and such disagreements are often the reason why the feature had been commissioned. Sometimes there is a debate as to whether or not a condition exists (chronic fatigue syndrome, adult attention deficit hyperactivity disorder) or whether it is the medicalisation of a collection of random physical or psychological symptoms. These sources have undergone training, have specific expertise and their views based on published evidence. They have a common understanding of how the body functions and they work within the National Health Service – commissioning editors rarely cover treatments their readers cannot afford. It was important that I (and my commissioning editor) understood the condition and precisely how the treatment worked.

This was not the case with CAM practitioners and researchers. Most theories underpinning these modalities have no basis in scientific literature and commissioning editors knew this and so rarely asked for any detailed explanation of such mechanisms.

There was rarely contradictory evidence from sources about a therapy (unless it was a herbal treatment), unless I was asked to provide copy that was critical of a specific therapy.

Sometimes, I would not include information from such sources. Not only would it conflict with medical knowledge of the physiological workings of the body, but also because it was poor advice for the reader, such as in the following extract from an interview I conducted for *The Which? Guide*

“We do a lot of detox approaches – skin brushing, drinking a lot of water, use of homeopathic medicines and nutritional medicine. They are doing good if the patient feels ill. They are detoxing...conventional medicine has no concept of this sort of toxicity. We get a 60 per cent clinical improvement following removal of amalgam fillings. It’s £500 per patient, but we only recommend it on patients with MS and severe chronic fatigue syndrome. Our charges are high because we are medical.” (interview, Dr Julian Kenyon, co-founder of the Centre for the Study of Complementary Medicine in Southampton, February 1996)

In my conclusion I will explore the willingness to believe the claims of CAM, which became almost a collusion between editors and audiences. I will explore the theory of “magical” thinking, the lack of scientific knowledge among audiences about recovery from illness – and why journalists were and still are reluctant to give logical reasons for the seeming success of CAM.

Chapter 7: Savvy or Suckers? Why CAM “works”

“Why,” asked the psychologist and leading sceptic Barry Beyerstein, “...do so many otherwise intelligent patients and therapists pay considerable sums for products and therapies of alternative medicine, even though most of these either are known to be useless or dangerous or have not been subjected to rigorous scientific testing?”

(Beyerstein, 2001)

In this final section, I will endeavour to answer his question. Like Beyerstein, I am curious to understand why, in the face of the paucity of scientific evidence, CAM was and remains popular with consumers. I believe its popularity with editors has waned and this view is borne out by Victoria Lambert, owner of Dysart Press and health editor of the *Daily Telegraph* from 2000-2002 and the *Daily Mail* from 2002-2006 and Jane Symons, a media consultant and health editor of *The Sun* from 2004 to 2009. Lambert is chair of the Medical Journalists’ Association and Symons is on its executive committee. I conducted email interviews with both of them for this dissertation.

Entering the phrase “complementary and alternative therapies” into Nexis UK and searching under the category UK newspapers and broadsheet newspapers for 1985-1990, returned 16 results for both categories. The same search for 2000-2005 returned 556 and 127 results respectively and for 2010-2014, some 22 and 38 results. I shall comment on these figures later in this section. Lambert suggests:

“I think there is a lot less coverage and that is partly fashion – complementary stuff just isn’t so new these days so it has to fight its case with everything else. But I think we also became less trusting of it as the move towards evidence-based everything came through. Science just doesn’t bear a lot of the complementary claims out, and increasingly papers won’t run anything without some science for fear of looking stupid.” (email communication Victoria Lambert, 12 June 2014)

To discover why CAM was so popular, I have examined scholarship in number of areas including sociology, science, media studies and cultural studies – each displaying some understanding of each other’s views, but also frustration with them. I have also examined scholarship on belief (with particular reference to CAM, as opposed to other “weird” beliefs, such as alien abduction), as well as the neuroscience that provides a mental framework for such beliefs.

When it comes to scholarship on CAM use, MacArtney and Wahlberg identify three distinct academic approaches. First there are the *advocates*, who celebrate CAM as an antidote to a “toxic” biomedicine; then there are the *pragmatists*, who argue that regulatory measures should be taken to ensure that practitioners are responsible and

ethical and CAM products safe. Finally, there are the *opponents* who are worried that a rise in CAM is putting patient safety at risk and that consumers are being duped into buying snake oils and miracle cures by the “enemies of reason”. (MacArtney and Wahlberg, 2014)

The mainstream view of scientists, who tend to be sceptics (the opponents), is that continued CAM use is a “problem”. Few CAM modalities have undergone randomised double-blind placebo-controlled clinical trials, the “gold standard” of clinical efficacy, and the mechanisms underpinning many of them are biologically implausible. Consequently, CAM users are labelled as “ignorant and gullible”, “uneducated and dull-witted” and “suckers” (Beyerstein, 2001, Gilovich, Shapiro).

For most sociologists (pragmatists), CAM use is not seen as a problem of scientific evidence and efficacy, nor a challenge to the biomedical establishment. Consumers are reflective pragmatists, “who want to understand the meaning of illness as much as they want to be cured, and when biomedicine cannot or does not assist them in this endeavor they will look elsewhere, using their body as a testing ground for meaning” (MacArtney and Wahlberg, 2014: 118).

For most cultural studies scholars (also pragmatists), increased use of these therapies is much more than a medical, economic or even social phenomenon. It opens up a new “cultural terrain” and is “an increasingly new form of *cultural practice* [sic] bound up in new forms of bodily understanding and reception and new conceptions of selfhood” (Barcan: 2). Sociologist Nikolas Rose has coined the term “somatic ethics”. He argues that human beings, far from being narcissistic and self-absorbed, are increasingly coming to understand themselves in somatic terms – in other words, through their bodies.

As I have shown earlier in this dissertation, far from being ill-educated, CAM users tend to be well-educated, affluent, urban and predominantly female and middle-aged (Fulder, 1988; Sharma, 1992; Thomas *et al.*, 1991; Eisenberg, 1998; Kelner and Wellman, 1996). So while some CAM users are doubtless gullible, and those with terminal disease may be desperate, it is unlikely that they are “uneducated and dull-witted”.

CAM and the Will to Believe

Scientists and sceptics have listed compelling reasons why the “will to believe” is so prevalent among users of CAM (Beyerstein, 1997 and 2001; Singh and Ernst, 2008; Goldacre, 2009; French in Stein, G., 1996).

First is a lack of medical knowledge. Many diseases, such as allergies and dermatological and gastrointestinal conditions, are cyclical, with fluctuating symptoms. People often turn to CAM when their symptoms are at their most severe, thereby attributing any improvement to the therapy. Conventional treatment, taken alongside CAM, may have taken effect around the time the consumer decided to turn to a CAM remedy, and given time, the body usually heals itself. Most practitioners dispense general health advice and so this may also have had a positive impact.

Then there is the placebo effect. There has been intensive research activity in this field in recent years, especially in the neurobiological mechanisms involved in the placebo response. It is a highly complex area, spanning psychology and neuroscience.

A placebo is “a sham treatment without biological activity” and the placebo effect “a change after a placebo intervention” and “an effect caused by a patient-provider interaction” (Ernst, 2007). Through a combination of suggestion, expectancy and cognitive reinterpretation, patients given biologically useless treatments can often experience subjective relief. In other words, the placebo effect works by unconscious conditioning and conscious expectation (Ernst, 2007). In this way, many CAM treatments are highly effective, but for psychological reasons. Some modalities, such as homeopathy, flower remedies, crystal therapy and spiritual healing, work entirely through the placebo response (Beyerstein, 2001).

Evidence is growing that the relationship between the patient and doctor/practitioner is more powerful than previously thought. Eisenberg and Kaptchuk postulate that the “unique drama” of CAM therapies may have “enhanced” the placebo effect in particular conditions (Eisenberg and Kaptchuk, 2002). This “unique drama” is found in “magical” thinking, defined by cultural anthropologist Phillips Stevens Jr. as a belief in independent forces in nature, separate from those measured by science, which are energised by a mystical, transferable power that exists in all things (Stevens Jr., 2001). Chinese *qi*, Indian *prana* and power “concentrated” in crystals and colours all fit neatly into this paradigm.

Research has demonstrated that the placebo effect can stimulate physiological responses, affecting heart rate and blood pressure and changing chemical activity in the brain.

Dopamine and endorphins – the body’s natural painkillers – are now understood to be mediators of the placebo effect and brain imaging techniques have shown that placebos can mimic the effects of active drugs, sometimes in the long- as well as short-term, for depression, pain and Parkinson’s disease (Ernst, 2007; Petrovic, 2010).

Psychologist Chris French, founder of its Anomalistic Psychology Research Unit at Goldsmiths College, University of London, writes that placebos have “no effect on the progress or outcome of disease, but they may exert a powerful effect upon the subjective phenomena of illness, pain, discomfort, and distress”. If one receives a particular treatment for a particular illness “it is very natural to assume that the treatment caused the improvement” (French, in Stein, G.: 598).

Once held, beliefs are hard to dislodge, let alone dismantle. Scholars researching belief point to the “mental gyrations” that the mind performs to process information that challenges or threatens to overturn closely-held beliefs (Beyerstein, 2001). People strive to maintain consistency in their beliefs, often at the expense of truth, and this reluctance to relinquish one’s beliefs “permeates all walks of life”. (Sutherland)

Persuasive too are anecdotes. These, as Gilovich notes, can be distorted by the desire or need to tell “a good story”, as well as to inform. This can sometimes put the truth in jeopardy and can be further exaggerated by a media that distort “many not-so-amazing events to make them appear extraordinary, and sometimes even passes on complete fabrications from unreliable sources.” (Gilovich, 1993: 100)

Psychological research has demonstrated that people adhere to the views of the groups to which they belong, adopt the same behaviour as their peers and are persuaded by messages from an expert or person of high credibility. Most people are highly susceptible to the “halo” effect, whereby a person who has one salient trait, or is celebrated in one arena, such as acting, is likely to be judged as better than they really are in a different arena (Sutherland: 32-38).

When these beliefs are challenged, people enter a state of “cognitive dissonance”, tend to seek confirmation of their current hypothesis, rarely look for contradictory evidence and refuse to believe or act on it if brought to their attention (ibid. 100-103).

Nevertheless, the idea that consumers are driven by hard-wired neural connections or cognitive heuristics to accommodate their use of CAM is only partially accepted by the majority of sociologists. Their scholarly work shows that many consumers take a “hybrid” approach to their healthcare and use CAM as a supplement to, rather than a substitute for, biomedical care (Thomas, K. *et al.*, Sharma; MacArtney and Wahlberg). Users talk of “control and empowerment” and the evidence from sociologists is that consumers are not wholly sceptical of biomedicine and blindly accepting of CAM (Britten, 2008; Broom and Tovey, 2008; MacArtney and Wahlberg).

As a cultural studies scholar, Barcan also regards this “consumer-led sampling of

different modalities” as evidence of control and central to success in health. Indeed “control” is an axiom when it comes to health care, she writes. In choosing CAM, consumers display a range of “cultural dominants”, which converge and coalesce.

“The desire for control meets the search for pleasure but it may also rub up against the concept of the spiritual journey with its unknown goal; the frisson associated with resistance to medical orthodoxy often sits alongside a sense of consumer entitlement.”
(Barcan: 39)

Wresting control from “paternalistic biomedicine”, CAM users are viewed as discerning, educated consumers “with a sense of entitlement, money to spend, and belief in consumer choice”. (Barcan: 37)

“Alternative therapies may have spiritual origins and a countercultural history, but they have a neoliberal present.” (ibid)

This sense of entitlement, and money with which to indulge it, has allowed CAM to proliferate and, like a virus, to change and strengthen. There is now a cornucopia of modalities and as one falls into disrepute, is exposed as fraudulent or dismissed as unfashionable, another emerges – newer, fresher and more enticing than the last. Peter Canter (2003) points out that new modalities often synthesise two or more existing therapies, such as acu-yoga (acupressure and yoga) or Zen-shiatsu (meditation and shiatsu massage). Being “the latest thing”, says Canter, has obvious commercial advantages.

“Fashion is clearly an important factor in the development of CAM just as it is in psychotherapy, diets and exercise programmes. All have grown in parallel with disposable income and with a growing belief that for every ailment and discomfort, mental or physical, there must be a cure.” (Canter: 168)

Conclusion: Editors and Evidence: from Hero to Zero

In its 1986 report, the BMA dismissed CAM as “passing fashions”, yet it flourished in the late twentieth and early twenty-first centuries, buoyed up on a tide of consumerism, new ways of thinking about the body and the self, and a dissatisfaction with biomedicine.

Were book publishers, editors and journalists dazzled by its potential, succumbing to group pressure from an overwhelming majority, including highly-placed sources? Just like the subjects of Hans Christian Anderson’s vain and naked emperor, were we ignoring the evidence in front of our eyes?

I believe in some parts of the media there was an element of that. Nevertheless, as journalists writing for broadsheet newspapers and reputable publishers, we researched the therapies carefully and endeavoured to serve our audiences with the best evidence we could find.

Over the past two decades, a considerable body of evidence looking at the efficacy of CAM has built up, patiently outlined by scientists, of which Ernst and Goldacre are the most prominent and have produced the most detailed summaries (Ernst, Pittler and Wider, 2006; Singh and Ernst, 2008; Goldacre, 2009).

For journalists like myself, operating in the field between 1990 and 2005, and for our commissioning editors, this research was in its infancy. Colleagues, most of whom were medical journalists, reported that they spent a considerable amount of time scrutinising studies, searching for the efficacy of various CAM treatments and rejecting those that had few, if any, clinical studies to underpin them.

I saw little evidence either that commissioning editors were attempting to mislead readers. Many editors rejected the more esoteric therapies, or herbal remedies supported by little or no evidence, and rarely excluded critical comments, as in this example from an article I wrote in the *Daily Telegraph*:

“If something as relatively simple as royal jelly gave so much benefit, we would be on to it like a hot potato,” says Dr Rajan Madhok, a consultant rheumatologist at Glasgow Royal Infirmary. “But at present there is very little clinical evidence that it does any good.” (“Does it Work”, 5 March, 1999: see Volume 2)

CAM was newsworthy because it was relevant, unambiguous and close to the demographic culture of the mid-market and broadsheet newspapers. While features do not adhere strictly to the new values (Galtung and Ruge, 1965), commissioning editors require a news “peg”, such as new research, or at the very least topicality. More relevant are the contemporary set of news values outlined by Harcup and O’Neill, who revisited

Galtung and Ruge's original criteria (Harcup and O'Neill, 2001). These 10 updated criteria include stories with positive overtones ("good news"), stories with an element of showbusiness and human interest ("entertainment") and stories that are perceived as sufficiently significant either in the numbers of people involved or in potential impact ("magnitude").

Nevertheless, there was something else at work in the frenzy of CAM coverage, which was to peak in 2000-2005. This was highlighted by both Lambert and Symons. CAM was more than a passing fad; it was deeply fashionable, the latest new thing, as Symons comments:

"A lot of these therapies etc., were 'new' in terms of media coverage 20 years back, so there was a certain novelty factor." (email communication Jane Symons, 12 June 2014)

This CAM frenzy, which was reflected in the media coverage, was the opposite of a moral panic; it was euphoria, bound up with social status. Someone who regularly visited a CAM therapist was not only indulging in this "intertwining [of] medicine, pleasure and consumption" (Barcan: 215), but seen to be doing so by his or her peers.

There is considerable scholarship in the field of moral panics and "folk devils" (Young, 1971; Cohen, 1972; Goode and Ben-Yehuda, 1994), all of which has provided sociologists with invaluable analytical tools. However, as Wood and Flinders, note there has been comparatively little research on the mirror image phenomena – that of collective joy, celebration and hope (Wood and Flinders, 2012). They focus on these mirror images – from "folk devils" to "folk heroes" and from "moral panics" to "moral euphoria" – and analyse the dynamics that stimulate the transition from positive to negative social interpretations. In other words, how a social phenomenon, such as CAM, can move from "hero" to "zero".

There is a disparate body of literature around episodes of intense and widespread joy or celebration that often orientates itself around popular heroes. Wood and Flinders cite Lofland's 1982 analysis of "crowd joys", in which he identified five criteria with which to measure the "joy" in social crowds – duration, the proportion of people displaying joy, how significant this joy was seen to be, the amount of activity combined with a display of emotion, and whether there was a sense of the joy being predesigned or planned.

CAM does not entirely fit into this sociological template. Nevertheless, from 1990-2005, peaking around the turn of the century, CAM was written about and talked about widely and positively. In terms of its framing, CAM moved from "folk" medicine to "integrated" medicine and its "folk heroes" were its advocates – the chiropractors, homeopaths and practitioners of Eastern medicine that appeared to offer so much to consumers.

Stories on CAM in UK Newspapers: 1985-2014		
Time Scale	UK Newspapers	Broadsheet Newspapers
1985-1990	16	16
1990-1995	226	83
2000-2005	556	127
2005-2010	469	124
2010-2014 (July)	220	38

Source: Nexis UK

The search on the Nexis UK database under the phrase “complementary and alternative medicine” and the category “UK newspapers” and “broadsheet newspapers” revealed a steady increase in media coverage. Applying Lofland’s criteria, the peak was 2000-2005 – the height of “crowd joy”.

There are many reasons why less media coverage is devoted now to CAM. Much of the “crowd joy” has been drowned out by a vocal group of sceptics, all of whom are enthusiastic users of social media. The Nightingale Collaboration, a not-for-profit organisation that challenges misleading claims by CAM practitioners and subjects these claims to scrutiny, was launched in 2010.

The rise of evidence based medicine (EBM), where treatments are systematically reviewed and appraised using clinical research in order to determine best practice, has resulted in a reluctance among many health editors to publish articles on complementary therapies that are not supported by scientific data. One of the most respected authorities in the field of EBM is The Cochrane Collaboration, a global independent network of scientists and researchers, who undertake systematic reviews of treatments, sifting through a multitude of studies to provide some kind of definitive judgment on them. Such systematic reviews have shown that there is little significant evidence for many CAM therapies.

It is this lack of evidence – highlighted by sceptics – that influences not only commissioning editors, but experienced freelance journalists, such as Symons.

“I think sceptic groups...have certainly made journalists more aware of the need to investigate claims and their drip feed of 'show me the evidence' type questions ... [has] certainly increased awareness in the media, and generally, of the need to examine all claims – whether from alternative or traditional therapists or medics.” (email communication Jane Symons, 12 June 2014)

The ranks of homeopaths, naturopaths, herbalists, nutritionists etc., are now excluded from the media discourse in UK newspapers, transformed from “folk heroes” to “folk devils”. Chiropractors have been damaged in the eyes of many editors by trying (and failing) through the British Chiropractic Association, to sue science writer Simon Singh, who in 2008 labelled their claims as “bogus”. Since 2008, consumers have less disposable income to spend on such therapies and products. Mainstream medicine has become more “user friendly” and younger clinicians are less paternalistic.

CAM now is neither new, nor unexpected and is fragmenting into more evidence-based modalities, such as herbal medicine and acupuncture, a large pool of unproven but vaguely sensible sounding therapies, such as aromatherapy and hypnotherapy, and an increasingly silly fringe, such as distance healing and angel therapy.

The journalistic spotlight has moved on, and many journalists, like myself, are unsurprised by the mounting evidence that CAM does not bear too much scrutiny. For a story to be published, there has to be a fresh angle. Almost two decades on, the explanatory A-Z structure is stale, as Symons comments:

“There is probably also an element of journalistic fatigue – we've heard most of the stories before. Yes, I think there is less coverage of complementary and alternative remedies, and to be honest, I think that's good thing. I am far more likely to write a negative or questioning piece about complementary therapies.” (email communication Jane Symons, 12 June 2014)

Why coverage of CAM matters

Does it matter that CAM is getting less coverage in national newspapers today? For a journalist it may seem a pointless endeavour, as negative trial results seem to have little effect on the decisions made by people buying complementary and alternative treatments, who appear to lend more weight to anecdotal rather than scientific evidence (Cantner, 2003).

However, I would argue that CAM needs *continual*, not occasional, revisiting in the media. Among the potpourri of modalities, there needs to be a delineation of what may be effective and has been accepted by mainstream medicine (acupuncture, clinical hypnotherapy, some herbal medicine, massage therapy) and what fails to work or can be dangerous. Audiences should be reminded continually that charlatans, peddling their products, ill-informed or dangerous advice and bizarre diagnostic techniques, can flourish in an unregulated billion pound industry.

This sifting of CAM therapies through a filter of hard evidence – and the findings presented in mainstream media – is important because CAM continues to thrive. The

total UK annual spend on CAM treatments is £4.5 billion (Intel report, 2009). Between 2011-2016 the number of consumers using CAM treatments is estimated to grow by 60% and the number of CAM practitioners – currently 40,000 – is estimated to grow by 30% (British Lifestyles Report, Intel, 2011). Many people move between mainstream medicine and complementary therapies, supplementing antibiotics with spiritual healing, chemotherapy with reiki in a welter of “medicine, pleasure, recreation, consumerism and spirituality.” (Barcan, 2011: 213)

However, far from being a pathway to “wellness”, CAM can, in certain circumstances, be dangerous. The academic literature on the subject lists numerous adverse events from mild skin reactions and gastrointestinal disturbances to stroke (chiropractic), severe bleeding (acupuncture) and liver failure (herbal medicine) (Rowlands, 1997; Ernst, 1995; Ernst, Pittler and Wider, 2006; Wong, 2006; Singh and Ernst, 2008; Jacobsson *et al*, 2009; Lim, Cranswick and South, 2010; Bello *et al*, 2012; Sweet *et al*, 2013). As old therapies transmute into new ones, so the opportunities for psychological and physical damage increase, and evidence-based assessment of these therapies can never keep pace. Broken ribs, torn Achilles tendons, retinal damage and strokes have resulted from commonly taught yoga postures (Broad, 2012).

A recent study shows that liver injury caused by herbal and dietary supplements increased from 7% to 20% in a group of 839 patients with liver injury over a 10-year period (Navarro *et al*, 2014). More dangerous are patients delaying (or even omitting) conventional treatment in the misguided hope that CAM will effect a cure. The desperate and terminally ill can spend their life savings on having treatments at organisations such as The Gerson Institute in California and The Burzynski Clinic in Texas, both of which claim to cure cancer and chronic conditions through “non-toxic” treatments.

In early September 2014, the Medical Practitioners Tribunal Service (MPTS) ruled that claims made by Dr Julian Kenyon, who runs the Dove Clinic for Integrated Medicine in London (and who I quoted on p.41), that his sound-wave and light-bed treatment caused “significant tumour cell death” in eight out of 10 patients, was not backed by good science and could not be justified (‘Patients misled on alternative cancer care’, *The Sunday Times*, 7 September, 2014).

While a number of books, critical of CAM have been published recently, as I outlined at the beginning of Chapter 2, there is no evidence that the public appetite for CAM has diminished, so strong is the will to believe. A *continual* revisiting in the media of CAM treatments, therapies and products would re-frame the industry as one of which consumers should be wary – unregulated, unaccountable, not necessarily safe and not an

equal alternative to biomedicine.

Reflecting on my own practice in the process of researching and writing this dissertation, two issues strike me as worthy of further investigation. First, I keep returning to the academic focus on the newsroom and apparent lack of scholarly interest in the role of freelance journalists in news organisations. This is something I discussed earlier in this dissertation on the chapter on sourcing.

The relationship between staff correspondents and editors is significantly different to that between freelance journalists and commissioning editors. Freelance journalists, often liberated from a tight deadline and the daily news agenda, have the time to investigate stories in more depth, add colour through their own or other people's experience, analyse trends, question academic research and filter information. With the shifting of the news agenda through digital disruption and the increased popularity of blogging and longform journalism, I would argue that freelancers, with their independence, expertise in delivering stories in different styles and increasingly across platforms, are becoming more important.

They have moved away from the traditional news agenda, fuelled by breakthroughs and hard news events. Many are women, having "drifted" from staff to freelance, especially after they have become mothers (Franks, 2013), and are liberated from the traditional hard news agenda – what Ross calls the "malestream" (Ross in Allan, 2005) – and this will continue to have an impact on how health journalism is delivered to audiences.

Second, there has also been little scholarship on the increasing use of the case history as a prism through which to filter information. In health journalism, these "pathographies"¹⁰ are used to give coherence to the experience of illness and any accompanying treatment, whether mainstream or alternative. However, as McKay and Bonner note in their examination of breast cancer pathographies in Australian women's magazines (1999), the quality of medical advice included in these stories can sometimes be devalued and there is pressure on journalists to produce "positive statements about triumphing over adversity" (569). Both of these are neglected areas of journalism scholarship, but important and fruitful areas for investigation.

If there is little coverage now of CAM in national newspapers, its legacy remains in the subtle shift in features health journalism from stories focusing on illness and disease and mainstream treatments, to wellbeing pages, filled with personal stories that relate how audiences can take control of their own health through dietary or fitness regimes. Such

¹⁰ personal narratives about illness and treatment

journalism, usually positive and sometimes lacking any scientific evidence, does little to truly inform audiences and give them real health choices. And that is something that should cause real concern.

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PERSONAL COMMUNICATION

email communication Victoria Lambert, 12 June 2014

email communication Jane Symons, 12 June 2014

APPENDICES

The following is a list of publications of Barbara Rowlands relevant to the submission for PhD by prior publication. The following focus on self-help and complementary therapies, approximately a quarter of my journalistic output.

Published articles: National Newspapers

- 'Does it Work? A Herb that Might Keep you Mobile', *Daily Telegraph*, July 1998
- 'Does it Work? A juice that cures (cranberries)', *Daily Telegraph*, 1 January 1999
- 'Does it Work? Conkers can cure – it's no game', *Daily Telegraph*, February 1999
- 'Does it Work? Blue-green algae', *Daily Telegraph*, 30 April 1999
- 'Does it Work? Bee food that gives you a buzz', *Daily Telegraph*, 5 March 1999
- 'Japan's menu for the menopause' (supplements), *Daily Telegraph*, 16 February 2000
- 'A pot full of potential: can a cuppa ward off illness,' *Daily Telegraph*, 1 June 2000
- 'Trying to find the perfect balance (Anthroposophical medicine)', *Daily Telegraph*, 31 July 2000
- 'Charms can calm, but don't risk those rays (electronic "health" charms)', *Daily Telegraph*, 29 August 2000
- 'Fancy an aphrodisiac? Try some royal jelly, liquorice – or porridge,' *Daily Telegraph*, 9 February 2001
- 'Go on, treat the children (Aromatherapy)', *Daily Telegraph*, 7 March 2001
- 'Does it Work? 'Watercress packs a punch against cancer', *Daily Telegraph*, 16 July 2001
- "Does it Work? Sports Drinks Soaring Away', *Daily Telegraph*, 23 March 2004
- 'Exploring Alternatives: Qigong', *The Express*, 24 February 1999
- 'Exploring Alternatives, Kinesiology', *The Express*, 17 March 1999
- 'Tibetan Medicine: Mind, Body, Spirit', *The Express*, 31 March 1999
- 'Exploring Alternatives: Chiropractic', *The Express*, 21 April 1999
- 'Exploring Alternatives: Alexander Technique', *The Express*, 19 May 1999
- 'Exploring Alternatives, Ayurveda, *The Express*, 5 May 1999
- 'Exploring Alternatives: Naturopathy', *The Express*, 23 June 1999
- 'Exploring Alternatives: Yoga, *The Express*', 21 July 1999
- 'Exploring Alternatives: Hypnotherapy', *The Express*, 15 September 1999
- 'Exploring Alternatives, Therapeutic Touch', *The Express*, 13 October 1999
- 'Say a Mantra for your Heart', *The European* magazine, February 1995
- 'Stressed Out? Let your feelings flow', *The Independent*, October 1996
- 'Useless. Dangerous. Even crooked. The brutal verdict on our most popular complementary cures' (interview with Professor Edzard Ernst), *Daily Mail*, 12 December 2006
- 'A remedy that's all in the mind?' (Echinacea), *The Times*, T2, 18 May 2004
- 'Getting your vitamins? Well not for much longer', *The Times*, T2, 9 September 2005

'Wholly mackerel – are you eating your fish quota?' (fish oil), *The Times*, T2, 19 August 2005

Published articles: Magazines

'Self-help for Hiatus Hernia', *Prima* magazine, October 1993

'Natural Healing', Complementary Care column, *BBC Good Health*, May 1993

'The Chinese have a cure for it (Chinese Herbal Medicine)', *Now* magazine, June 1996

'Easing Pain...Without Drugs', *Now* magazine, March 1997

'Stand Tall: The Alexander Technique', *Now* magazine, September 1997

Scents & Sensibility: the power of smell. *Vegetarian Good Food*, 1998

'Testing Times: food intolerance tests' *Vegetarian Good Food*, May 1999

'Your Health: What's making the news in conventional and complementary healthcare,' *Woman and Home*, May 1999

'Your Health: What's making the news in conventional and complementary healthcare,' *Woman and Home*, June 1999

'The Great Vitamins Debate', *Here's Health*, November 2002

'Wise up to the Weather', *Tesco Healthy Living*, February 2003

'Ayurveda for mind and body' *At Home with Penny Smith*, GMTV 2000

Complementary Medicine; a safe pair of hands? *Candis* magazine, January 1998

'The Great Vitamins Debate', *Saga* magazine, November 2002

'Hypnosis set me free: gut hypnotherapy' *Yours* magazine, September 2009

Books:

Alternative Answers to Asthma & Allergies (Marshall Publishing, 1999)

The Which? Guide to Complementary Medicine (Consumers Association, 1997)

The Troubled Gut: Self-Help for Irritable Bowel Syndrome (Headline Book Publishing, 1996)

Academic Reviews

Rowlands. B. (2002) Review: Cohn, V and Cope, L. 'News & Numbers: A Guide to Reporting Statistical Claims and Controversies in Health and Other Fields' in *Journalism: Theory, practice and criticism*. Vol 3 (3): 373-374

Rowlands. B. (2003) Review: Levi, R. 'Medical Journalism: Exposing fact, Fiction, Fraud in Journalism' in *Journalism: Theory, practice and criticism* Vol 4 (1): 133-134

Example of responses to feedback from Which? Books

FAX

To: Emma Johnson
From: Barbara Rowlands
Date: October 1996

Here are some points answered. I have various case studies on file (one a GP practice, drug centre, etc) and will fax them later. On point 4 of General Points, while I suggested therapies in my outline, I was given a list of them by the CA. This bit needs some thinking, and I'll come back to you on this.

General Points

1. To come
2. I've rewritten some of page 4 and hope it makes it clearer:

The terms 'alternative' and 'complementary' are both still relevant. Complementary therapies complement or work alongside, mainstream medicine. As cancer patients are being treated with chemotherapy or radiotherapy, so they can have massage, aromatherapy or reflexology to alleviate the stress and discomfort, both of the illness and the orthodox treatment.

Some therapies, such as osteopathy and chiropractic, accept most of the underlying principles on which modern medicine is based, in terms of anatomy, physiology and cause of disease. These therapies can happily run in tandem with mainstream medicine.

There are therapies such as homoeopathy, herbal medicine and acupuncture, which are 'alternative' treatments and can be used in place of mainstream medicine. Traditional Chinese Medicine, for example, has a completely different approach to the body than orthodox medicine. In reality, many treatments originally designed to replace orthodox medicine, are used alongside conventional treatments.

Acupuncture is often used alongside orthodox treatment and is frequently used in mainstream medicine as a form of pain relief. Elderly people and those with mental and physical disabilities can gain a sense of peace and calm through touch therapies, such as reiki or the metamorphic technique, while still taking their medication

But all reputable complementary practitioners bend over backwards to work alongside doctors and would never advise people to come off medication. Many therapists work directly alongside doctors in GP practices and hospitals and many doctors are happy to send patients with chronic ailments, whom mainstream medicine has failed, to complementary therapist who may succeed.

The main problem with complementary medicine is that it is a very broad church. It contains around 160 therapies headed up by acupuncture, homoeopathy, herbal medicine, osteopathy and chiropractic, but also including crystal therapy, flower remedies, colour therapy, sound healing and colonic hydrotherapy. Some have been the subject of extensive scientific study, others have not. Some therapists are highly qualified and wholly committed, others are not. All are, to some extent, tarred with the same brush.

By the turn of the century, it may well be that the terms 'complementary' and 'alternative' will be dropped altogether and that complementary and alternative therapies will be part of 'medicine'. With an increasing evidence to back up the claims of certain therapies, it may well be those therapies will be fully incorporated into mainstream medicine and will just be part of a package of healthcare given to patients as a matter of course.

Specific Points

1. The one in four figure comes from Andrew Vickers's letter to the *BMJ*, 1994, 309: 1161: Use of complementary therapies. The Consumers Association carried out a survey in 1992, which suggested that one in four of those surveyed had used complementary medicine in the previous year.

2. Dr Adrian White, research fellow in Complementary medicine at the University of Exeter, says in a paper, *Complementary Medicine is the GPs Concern*, for internal use on their training courses that "annual spending is probably in excess of £500m". The figure of £300m is from Andrew Vickers. The fact is no-one knows how much it is and you have to guess.

The Research Council for Complementary Medicine, quoting a report by Kate Thomas says that between 10-12 million visits to complementary practitioners are made a year. Vickers says that if you multiply that by £30 for each visit = £360 (12m x £30). The 1995 Mintel report on Complementary Medicine said that the OTC alternatives medicines market was £62.7m in 1994 -- add the two and you get £422.7m. So, you can delete both figures and say the total figure is £423m.

3. This is well-accepted hearsay and there is no hard evidence for it.
4. 'Last vestiges of Victorian table-rattling' -- means old-fashioned superstition and interest in the supernatural and occult. Delete phrase if you think no-one will understand it.
5. This figure is from a paper, *Complementary Medicine in Europe*, *BMJ*, 9 July 1994, written by Peter Fisher, consultant physician at the Royal London Homeopathic Hospital and Adam Ward, consultant orthopaedic physician. I think this is perfectly clear. People were asked whether they had visited a complementary practitioner in the previous 12 months and in 1985, one in seven said they had and in 1991, one in four said they had. *Which?* carried out a survey in August 1995 (published November). A questionnaire was sent to 20,000 readers and the response rate was 44%. (8,745). Asked the question, 'Have you ever used a practitioner or alternative (complementary) medicine?' 31% said yes. There were significantly more women who answered yes to this question. (40% v 27%)

Acupuncture:

P 61. para 2: The use of acupuncture on nausea and vomiting after chemotherapy is an area of research (though there are far fewer studies of this than of pain) but there is no evidence that it is used in hospitals, on as small scale, let alone widely. (Source: Dr Adrian White, Exeter, BAC)

para 3: This is pointed out clearly at the end of the chapter. Par 3 is a purely factual, and a comment such as this (which would show that we were on the "side" of non-medical practitioners) would not be useful here.

Doctors say they do have adequate training in acupuncture and maintain that as it is useful only for pain relief, years of training and a knowledge of the philosophy behind TCM are not needed. They also maintain they have a full knowledge of anatomy, which traditionally-trained acupuncturists may not, and that they, the doctors, are therefore safer.

The WHO attempted to solve the dilemma by stating that acupuncturists should acquire "a full understanding of their own limitations and those of acupuncture" and the BMA recently called for the registration and professional standards of acupuncture practitioners (ref: *The risks of acupuncture: Risk & Safety in Medicine*, 1994, Prof. Edzard Ernst).

There are two aspects of safety in acupuncture -- safety in the technique (knowing where

to stick the needles in) and safety in diagnosis. Doctors must win hands-down on diagnosis because it is what they are doing all the time. Non-medically trained acupuncturists may not know what they are dealing with, so they are possibly less safe on diagnosis. On safety in needling, White says there is little evidence for or against either.

bottom par: This is true, it can be painful -- though I think the word "discomfort" is better. Needles are usually inserted to a depth of a centimetre, according to Dr White. But they can be inserted up to five inches, depending on which part of the body the acupuncturist is treating. At the nail point, for instance, the needles would go in a millimetre: in the buttocks it could go in several centimetres. The more fleshy the part, the deeper the acupuncture point (source: Joseph Goodman, chairman of the British Acupuncture Council). Acupuncture points are usually quite close to the bone, so the deeper the bone, the further the needle has to go.

Traditional Chinese Medicine by Rey Tiquia, and published by the Australian Consumers Association says the acupoints have a diameter of five to 10 mm and an average depth of 17.9 mm.

What is important for the reader to know is that there are two basic "types" of acupuncture -- Chinese acupuncture and western or scientific acupuncture. The difference is in diagnosis and needling technique: a western acupuncturist won't think about energy travelling in meridians and will just use the needle as a tool; a traditionally- trained acupuncturist will be concerned with balancing energy and will use the needle almost to unblock or transfer energy.

para 4: I'm having problems tracing my source for this information about the number of students trained in China, though have a call into the Chinese Embassy.

P. 63 para 1: I gave examples, not the full works. If you want everything, include dryness, summer heat, fire, cold, wind and damp. These are known as the Six Pernicious Influences (Kaptchuk). The concept of yin and yang and yin/yang imbalance is fully explained in pars 2-4. This section is on the origins of acupuncture; information on blocked energy, etc., comes later.

para 5: The consultant is wrong here, as confirmed by Goodman. Acupuncture is most often used by doctors for pain relief and by acupuncturists for everything else (as well as pain relief).

P.68: para 2: *It is* alarming, which is why it was included. The study was undertaken in 1996 in Norway at the Institute of Community Medicine, University of Tromso (diagonal line through the o), Tromso, Norway, and published in *Complementary Therapies in Medicine* (1996), the main academic journal in the field. It is completely above board and respected by academics in the field. The researchers were Arne Johan Norheim, an acupuncturist, medical student and research scholar and Vinjar Fonnebo. MD. MSc, PhD, of the Institute of Community Medicine.

As I said in the copy, researchers sent questionnaires (in 1994) to randomly selected doctors and acupuncturists. A total of 1135 doctors and 197 acupuncturists responded. The criteria for the doctors was that they should be working doctors under 71, randomly selected for age and field of work. A total of 11,728 doctors met the inclusion criteria, and 1466 doctors were sampled. The questionnaire was returned by 1,135 doctors. A similar questionnaire was sent to 311 Norwegian acupuncturists found in the Yellow Pages of the telephone directory and 197 returned it.

The questions were: Have you ever in your practice met patients with acupuncture adverse effects? They were then asked to describe the number of incidents. The study does not give the total number of patients as it was not an RCT.

31% of acupuncturists reported adverse effects. Four acupuncturists reported eight

cases of pneumothorax after treatment, 132 reported fainting, 25 reported patients reporting increased pain after treatment and one reported 25 cases of nausea and vomiting. Adverse effects were reported by 12% of doctors. 21 reported 25 cases of pneumothorax. Local skin infections were most commonly reported adverse reaction.

The acupuncturists in the study have a total number of 1,280 years of practice. The study does not list the qualifications of the acupuncturists. I think it is important to include this study if you want a balanced chapter, and I will send you a copy if you want it.

More on pneumothorax: The paper, entitled *Complications of Acupuncture*, which reviews world literature on adverse effects, and is cited below, mentions 32 cases of pneumothorax worldwide, 126 cases of hepatitis, and 79 cases of drowsiness. The commonest side effect is bleeding on withdrawal of the needle. There have been reports of contact dermatitis to nickel, chromium and zinc, something called a Koebner phenomena, where you get a thickening elevation in the skin at the site of previous damage to the skin, for instance in cases of psoriasis. In the papers cited (over 100) there were a total of 395 cases of complications.

Acupuncture can be soporific and there is a potential risk where patients driving home after treatment may be a danger to themselves and others. In one study, published in the *American Journal of Acupuncture*, in 1986 56% of patients attending a pain clinic in Norway said they were “moderately drowsy” after treatment. The point of all this is that acupuncture is not risk-free.

para 3: I stick by my assertion that there are no such things as meridians. I haven't heard of skin biopsies around meridian channels and nor has anybody I have spoken to. I have discussed this at length with Dr Adrian White at the University of Exeter, has an acupuncture practice in Devon, as well as being a doctor and leading acupuncture researcher.

BIOFORCE VISIT TO SWITZERLAND

13 July - 15 July 2005

DRAFT ITINERARY

WEDNESDAY

1000 Check in at Heathrow Terminal Four, go through passport control and meet up opposite security at the British Airways customer services desk. Please allow plenty of time as it can be busy at this time of year.

1155 Depart Heathrow BA0714

1440 Arrive Zurich (Swiss time)

We transfer by coach to Hotel Metropol, Arbon. Arbon is an attractive small town, with shops, situated on the Bodensee, or Lake Constance. Our hotel is by the lake, with a small pool and lovely views.

Hotel Metropol 00 41 71 447 8282

Free time to settle in.

1900 Drinks reception and dinner at the Hotel Metropol

THURSDAY

Breakfast at hotel

0815 Transfer to Teufen, where Alfred Vogel, founder of Bioforce, began his work. Teufen is a beautiful location with views of the Alps. The original home of Alfred Vogel, now museum, a beautiful display garden and conference centre. Teufen is home to Remo and Frances Vetter who will be guides.

0900 Introduction to the philosophy and work of Alfred Vogel

Spend the morning visiting the garden etc plus

Seminars with Dr Jen Tan

- The advantages of fresh herb extracts and holistic standardisation
- Echinacea – the myths exploded

Lunch

Visit the museum and practical activities (eg making a fresh herb tincture)

Seminar with Dr Jen Tan

- Women's & Men's Herbs

Transfer to hotel and free time for walks by the lake, shopping, swimming ...

1900 Transfer for dinner at lakeside restaurant

FRIDAY

Check out from hotel

815 Travel to Roggwil, Bioforce HQ, a few minutes drive from hotel.

- 830 Demonstration of Echinacea harvesting, if conditions are favourable. Chance to join in if conditions are favourable. It might sound early but Bioforce start harvesting at dawn! Followed by A. Vogel breakfast in a tipi.
- 930 Garden tour, company presentation.
Seminar with Andy Suter
Devil's Claw and Arnica Gel, the latest research.
Healthy Way tour of A.Vogel's legacy.
Lunch
Leave for airport
- 1715 Depart Zurich BA0717
- 1800 Arrive London Heathrow (UK time)