Response to the draft Information Paper of the NHMRC on Homoeopathy

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The NHMRC released its draft information paper on homoeopathy for community consultation on 9/4/14, but has failed to adequately explain both internal and external contexts of this project. What is omitted is as important as what is stated: this document addresses these issues.

The call for submissions is expressed in a manner which attempts to limit the consultative process, and evade criticism of the process that has been so far followed:

'NHMRC will only give consideration to submissions that address the public consultation questions, are within the scope of the review, and meet the criteria regarding evidence discussed below.'

None of the three questions posed by the consultation allow for discussion of the appropriateness of the NHMRC's expressed 'beliefs' concerning homoeopathy, whether they are based upon the evidence base, or are appropriately expressed in regard to their stated objective - i.e. to provide accurate information to the Australian public. Such information should ideally be objective, free from bias and presented in an appropriate context.

Why did the NHMRC undertake this assessment?

The NHMRC states that in 2008 Australians spent $8.5 million on homoeopathic medicines, and that this level of expenditure necessitates the public provision of reliable information regarding the potential benefits and risks of this therapy. This figure contrasts with the $1.8 Billion in annual revenues for complementary medicine companies' sales in Australia [1], homoeopathy representing a mere 0.5% of these sales. Why therefore the NHMRC's initial focus on homoeopathy? This is particularly puzzling, given that the 'NHMRC did not assess evidence on the safety of ingredients of homeopathic medicines', presumably because they are recognised as being amongst the safest medicines available. Perhaps the most disturbing impact of homoeopathic medicine on the public policy

landscape is the choice by some people to use homoeopathic products for prophylactic purposes, yet the NHMRC chose not to investigate the evidence supporting this application of homoeopathy, avoiding discussion of the evidence for this use of homoeopathy.

The NHMRC also claims the need for this investigation because in the last 13 yrs it spent $86mill on complementary medicine research - yet neglects to indicate that this is less than 1% of NHMRC research funding, and none of this was spent on research trials of homoeopathy. Indeed the money spent on generating this report was probably the first NHMRC expenditure on homoeopathy research.

Australians using homoeopathy generally recognise that it is a CAM therapy, which by definition has a limited evidence base (because if it had a clearly convincing evidence base it would become mainstream). As the draft findings don't alter this position, and the NHMRC should have been well aware of this by the end of 2011, and certainly would have been had a decision been taken to discuss the matter with representatives of the 'homoeopathy industry', why spend $150,000 engaging in the current process (much of that going to colleagues in the Optum and the Australasian Cochrane Centre)?

The background of the NHMRC's 2011 leaked draft statement on homoeopathy is omitted from the Draft Information Paper, and is no doubt embarrassing to the NHMRC. It displayed the NHMRC's inability to discern the difference between a political and a scientific process [2], as the result of people with the agenda of organisations such as the Friends of Science In Medicine taking the NHMRC on a prejudiced course against homoeopathy. The current process follows this demonstration of bias. It is to the NHMRC's credit that it responded with a more appropriate process toward a position paper. Nonetheless, this history, combined with the lack of common sense concerning the stated reasons for the inquiry, the biased analysis methodology applied by the researchers and the manner of expression of the inquiry's conclusions are all indicative of the actual motives for the inquiry, which attempt to achieve the aims of the earlier leaked draft, without the embarrassment.

While the homeopathy market in Australia is currently relatively small, the global market for homeopathic medicines is estimated at $3-5Billion with strong annual growth. Limitations placed on CAM practitioners and manufacturers would principally benefit the pharmaceutical industry: the NHMRC inquiry has been reported internationally, as was the UK Parliament S&TC report of 2010, and these perceived negative reports on homoeopathy strengthen the market share of the pharmaceutical industry. **In 2013 the NHMRC initiated investigation of other CAM therapies, so it may be that homoeopathy is perceived to be an easy 'test case' from which to extend restrictive measures to the larger nutritional and herbal markets, which are likely to prove to be more difficult politically to restrict.**

How valid is the process for the stated aims?

The NHMRC anticipated that its review of homeopathy would take 6 months [2], but the size and complexity of the evidence base and the layers of bureaucracy placed onto the project have extended its duration to more than 3 years, with yet more evidence to be evaluated. The Homeopathy Working Committee (HWC) chose to save time, energy and money by reviewing systematic reviews rather than searching for and evaluating all the primary research data. This is contrary to the impression given on page 271 of the Overview report appendices, which suggests that this material was 'unavailable'. The OPTUM/NHMRC findings have been supplemented with some public submissions made in response to the leaked draft paper in 2011. A later submission by the Australian Register of Homoeopaths to the Natural Therapy Review Advisory Committee (March-April 2013) was directed to the HWC, but was not used to source further submitted evidence [2]. This document also provided research on safety and cost/benefit analyses of homoeopathy, which should have expanded the HWC's chosen scope of its review to encompass these important aspects of health care research, to fulfill its role of providing advice to the community.

The NHMRC also chose to ignore veterinary and laboratory evidence of the effectiveness of homoeopathy. It appears to think that the public are only interested in the health of humans, and shouldn't get confused by animals and cell cultures responding to homoeopathic medications in RCTs. This gives the

impression that the NHMRC has ruled out of scope anything which did not fit its brief (as displayed in 2011); namely to find a paucity of evidence for homoeopathy.

The NHMRC has also chosen to ignore Level lV (observational and outcomes) studies, where the effectiveness of treatments in real-world clinical conditions may be examined. British medical researcher Ben Goldacre [3] describes the irrelevance of many trial findings to real-world conditions as a “quiet, dismal scandal”, because (amongst other considerations) of the disparity between trial conditions and those of normal clinical practice. Included in the research material provided in submissions to the NHMRC are a number of large population studies, commonly of cohorts of 1500 to 6000 patients, drawn from homoeopathic outpatient clinics in the U.K. and Europe, which find very beneficial results of homoeopathic treatment. There is also compelling evidence of both the safety and the affordability of homoeopathic treatment, which compares favourably to the high-cost, side-effect-heavier conventional medical care. This evidence must be of interest both to the public and to public health policy researchers, yet Australia's chief medical research body has chosen to withhold this evidence.

The process adopted by the NHMRC has deficiencies and limitations (some of which are noted on Page 18 Draft Info Paper):

- Through the review of systematic reviews 176 primary studies were included, and a further 9 studies submitted (so far) by the public. However, by the time of the release of this draft paper there were at least a further 59 studies which appear to satisfy inclusion criteria (only 12 of which were published in 2013-14).
- Systematic reviews, especially those incorporating meta-analyses, may be of limited value in the absence of multiple trials using very similar trial design, in which case studies cannot be reliably combined. Where there are larger numbers of trials in one condition - eg the use of Arnica in exercise-induced muscle soreness, this may be because a context presents an opportunity to conduct a trial, rather than the therapy being

specifically indicated for the condition being investigated. (Exercise-induced muscle soreness is an experimental rather than a common clinical indication for the use of Arnica.) This limits the applicability of the conclusions in relation to usual homoeopathic practice.

- Because the reviewers only worked with the information provided by previous reviewers, and in most cases did not examine the primary research themselves, the method of homoeopathy used in some studies could not be identified, reducing the capacity to group studies appropriately for decisions about the overall evidence base. **The Optum reviewers did not attempt to clarify whether the previous reviewers correctly assessed the primary studies.** It appears that, for example, Heirs & Dean [4] mistakenly rated Strauss's 2000 study in ADHD [5] as an ineffective treatment. Further, when reviewers did not note the quality of a particular trial, or different reviewers reported data differently, **the HWC assumed the lowest quality option** 'to avoid any overestimation of the trial's quality' rather than examining the primary trial data themselves. This has the effect eg that in consideration of whether trials comparing homoeopathic treatment with conventional care demonstrated effectiveness, the existing trials were discounted because the systematic reviewers had provided no indication of trial quality, and the current reviewers therefrom assumed low quality, rather than examining the primary research (P30 Overview report).
- **The Optum reviewers considerations are open to question: for example,** the fact that the otitis media patients recovered as quickly on homoeopathy as the group who took antibiotics appears to have escaped the reviewer's attention, which focussed only on the 4 who were cured in 3 days on homoeopathy compared with 1 in the comparator group (P11 of the Review of Submitted Literature). Another otitis media trial (Taylor & Jacobs 2011) [6] was excluded because the reviewers presumed that the use of standard therapy in both treatment groups compounded the results (RoSL P46). Yet the authors specifically controlled for this variable and stated that the only noted difference in this regard was less use of

standard therapy (i.e. less need for antibiotics) in the homoeopathy treatment group.

- **The HWC appears to have excluded any not-in-English publication that their researchers would have had to read.** Bearing in mind that homoeopathy has its origins in Europe, and has a significant research base in German, French, Italian, Portuguese and Spanish, this decision by the HWC reduces the reliability of any conclusions reached, as in the case of sinusitis [7].
- Trials of prophylactic use of homoeopathy were excluded, of which there are more than 10 of varying quality. These suggest highly cost-effective interventions for the anticipated rise in mosquito borne viral diseases that will increase in Australia due to climate change. Bear in mind also influenza, and the near $200million probably wasted by the Australian government alone on Tamiflu [8].
- **Trials investigating individualised homoeopathy present particular methodological challenges for double-blinded RCT design,** especially when treating patients with chronic conditions, requiring assessments on multiple occasions for treatment decisions, when it is not known if the patient had received the active remedy or placebo. Not knowing whether to change the remedy, or repeat it because a placebo was last given, adds an extra variable to an already complex clinical decision, a variable not present in normal clinical practice. In other words, a clinician-blinded trial design may be appropriate to the testing of a single drug with a predefined dosage, but is not suitable for testing a system of medicine that requires decisions at every consultation, which include changing remedy, potency and/or dosing frequency. If trial design does not avoid such issues, then inappropriate conclusions may result concerning the effectiveness of the treatment in normal practice (being different to the trial conditions). One third of all RCTs of homeopathy have investigated individualised homoeopathy. In the 30 RCTs suffering from these design problems, 43% yielded significantly positive results for homoeopathy. Of the 37 RCTs designed in ways that avoid this problem, 78% were significantly positive

for homoeopathy. If only the double-blind, placebo-controlled trials of these 37 are examined, 80% of these are positive for homoeopathy. This reality leads to the conclusion that 30 RCTs utilising individualised homoeopathy probably concluded that the benefits of homoeopathy are less than they really are in practice. The authors of systematic reviews have not taken this into account, and despite being advised of this in submissions from the homeopathic community, the HWC appears to have ignored these issues in this draft report. **It could be said then that 'quadruple blindness' applies here: patients and clinicians being double blind in the primary trials, the systematic reviewers were blind to the inherent fallacy of the trial design in regard to external validity, and the HWC were blinded by prejudice because they didn't want to take account of the advice of this they had received.** Many of these problems have arisen as a consequence of refusing to include in the review team an expert in the practice of homoeopathy.

- Homoeopathic treatment effects are usually considered by homoeopathy's detractors to be placebo effects. Of the 209 RCTs of homoeopathy currently identified, if its benefits were due solely to placebo, based on the criterion of p-value > 0.05, a maximum of 10 trials only could be expected to favour homoeopathy. Countering the placebo-only argument is the fact that 109 of these trials find favourably for homoeopathy, displaying more than ten times the possible chance occurrence. Of the 162 trials using placebo as a comparator, 85 were found to be positive with $p < 0.05$, where one would expect only 8 to be positive if homoeopathy were merely a placebo.
- **The HWC have focused its attention on the effects of the medicine, attempting to exclude the effects of individualised consultations undertaken to decide on the medicine,** presumably on the arguable false assumption that a homoeopathic consultation is no more useful to the patient than any other consultation. This is appropriate in the context of OTC preparations used by people without professional consultation, however homoeopathic consultations are acknowledged as having a

greater capacity to generate healing effects resulting from the duration and complexity of the information gathering process [9]. Consequently by excluding studies that may demonstrate the added benefit of homoeopathy consultations (Level lV studies), **the HWC has chosen not to inform the public of the therapeutic benefit, which would have countered their concern about the risk, derived from interacting with a homoeopath.**

- **I**f the NHMRC's aim is to report to the Australian public on the benefits and risks of using homoeopathic medicine, **it is inappropriate to be reporting only on the evidence concerning efficacy, to the exclusion of the evidence concerning safety and cost, and to the exclusion of the context of these parameters regarding conventional medicine.** These parameters are not independent. For many years the regulation of medicines has been dealt with differently based on relative risk, and the quality of evidence required of products is strongly correlated with their cost. Cost is also limited by market competition when medicines cannot be patented, as is the case with most homoeopathic products. Consequently the current draft report does not adequately meet the requirements of the public, as it fails to include the history and reasons for the rising (over time) research quality bar that the NHMRC is applying, the fact that much of the examined research was generated decades earlier when that bar was lower, and the other contexts noted in this submission which were excluded, both from the investigation and the report.
- **The NHMRC chose not to include in the HWC any person with knowledge and experience with the management of patients with homoeopathic medicine.** This is contrary to the advice of respected EBM commentators [10 & 11]. By doing so the NHMRC could have saved time, money and avoided some of the complications of the inquiry's process, as indicated above. Instead, in order to provide the appearance of 'hands off reporting' to counter criticism of bias, Optum and the Australasian Cochrane Centre were engaged. **The conflicts of interest arising from that engagement are not disclosed in the Draft report, but it is**

evident that I am raising more concerns than their professional oversight has.

- Although the NHMRC claims it uses 'a rigorous approach developed by Australian experts in research methods' for reviewing & drafting health advice (DIP Page 5), on Page 271 of the ORA, we find: 'there is no relevant guidance or standard endorsed by the NHMRC or a relevant international organisation relating to the development and content of evidence statements.' So the HWC had to design a process to fit their necessity, contrary to one of their own inclusion criteria for acceptable primary research studies (Page 278 ORA), which is a potential source of bias.

Are the NHMRC's overall findings justified and appropriately expressed?

Research should reflect industry characteristics:

- The global prescription drug industry has a current annual turnover of around $1000Billion, which compares to $2.8Billion for homeopathic medicine sales. The development of drugs is an expensive process, largely because of the cost of trials [12]. Synthetic substances have a significant side-effect risk, which has led to the development of an increasingly rigorous evaluation regime over the last decades. **As a group, homoeopathic medicines are safer, and the industry is not organised around generating the same quality of evidence.** This is due to two characteristics of the homoeopathy industry: its products are not generally patentable, and practitioners / researchers are mostly generalists, who cannot individually collect patients in sufficient numbers to satisfy the quality criteria used by the NHMRC. While it is reasonable to consider trial quality in assessing the degree of reliance that can be placed on the results of trials**, it is unreasonable to give the impression that homoeopathy is ineffective on the basis that, despite having positive results, few or no trials have been conducted that were designed in a way that could provide a sufficient quality assessment.**

- The above error is further compounded by the fact that many of these trials utilised a homoeopathy prescribing process that differs from that used in normal practice. This is particularly inappropriate in the context that half of all primary RCTs showing significant benefit from homoeopathy. If homoeopathic interventions were ineffective, one would expect such a distribution of results from < 5% of the trials. Consequently **the evidence that does exist, as a whole supports the effectiveness of homoeopathy, but does so insufficiently to satisfy the quality and inclusion criteria set by the NHMRC**.
- The NHMRC criteria have been designed according to the risks, personnel and financial characteristics of a competing industry, rather than the industry the NHMRC is evaluating. Genuine research would be sensitive to the area under examination and seek to explore its application using appropriate parameters: the differing industry context and the resultant limitation on the ability of homoeopathy's researchers to satisfy the NHMRC's quality criteria is not reported by the NHMRC to the public whom they seek to inform. **A more accurate statement of the findings of this inquiry would be that on balance the totality of the evidence available suggests that homoeopathy may be an effective treatment. However, because of the quality of most of the trials, and that they are spread over many clinical conditions with few trial repetitions of the same homoeopathic intervention in any one condition, the NHMRC is not convinced by the evidence so far evaluated, that homoeopathy is effective in any one condition. Therefore the potential for safe, cost effective treatment utilising this modality warrants further targeted research.**

Trial quality vs homoeopathy's efficacy:

- **A significant error of logic was made by the HWC in assuming that homoeopathy was ineffective unless it could be proven to be effective** (to a quality standard that satisfies the NHMRC). Effectiveness of a treatment is independent of the system used to prove it, unless the

definition of 'effective' involves such proof. If the latter were the case, no treatment was effective prior to developing tests to justify the claim, and the effectiveness of treatments would therefore be dependent on the tests rather than the treatment. The HWC appears to purport that no treatment is effective before satisfactory tests have demonstrated that it is, as if the investigating tests somehow influence the treatment's effectiveness. The HWC has focused on the quality of the homoeopathy trials, rather than the results of the trials**. In fact they have identified that the trials lack quality, rather than that homoeopathy lacks efficacy.**

- The HWC did however make exceptions to its null hypothesis, when there were no studies, or the studies were singular and of poor quality, in which case it decided that 'no conclusion can be drawn about the effectiveness of homeopathy compared to placebo for the treatment of Y' (ORA page 278). When several studies (of insufficient quality) had positive findings the conclusion drawn was: 'Based on the body of evidence evaluated in this review there is **no reliable evidence** that homeopathy is more effective than placebo for the treatment of Y'. which is expressed in a way that sounds more negative than when there was less positive evidence. This has the effect of dismissing a body of evidence, even if it were almost sufficient to convince the HWC. ie regarding their reporting, 30% = 99% convincing evidence. Only 100% conviction changes the statement that 'there is no reliable evidence'. The NHMRC fails to find a way to acknowledge the evidence that lies between 30% and 99%, and thereby avoids giving credit for many positive studies of less than ideal quality. **This choice of words suggests prejudice, which has flowed into the NHMRC's 'beliefs' on Page 19 of the DIP, where there is no mention of the need for better quality research, despite the fact that the Research Gaps section 5.4 on Page 287 of the Overview Report contains the primary findings of the HWC's investigation.**

Bias in manner of reporting study assessments:

- In regard to placebo comparator (P279 ORA):'A significant difference in favour of homeopathy is reported by all (or a substantial proportion of) studies, but these studies are undersized and/or of poor methodological quality' was reflected by the HWC as: '3. Based on the body of evidence evaluated in this review there is **no reliable evidence** that homeopathy is more effective than placebo for the treatment of Y'
- in regard to other comparators: 'No significant difference (or a significant difference in favour of homeopathy) reported by all studies (or a substantial proportion of studies), but these studies are undersized and/or of poor methodological quality' was reflected by the HWC as: '3. Based on the body of evidence evaluated in this review there is **no reliable evidence** that homeopathy is as effective as [the other therapies] for the treatment of Y'.
- In response to Page 14 of the Draft Report, it is misleading to state that: 'Homeopathy is not more effective than placebo for the treatment of these health conditions'. Homoeopathy can be practiced in a variety of ways, so it would only be reasonable to say that the prescribing methodology used in each of the trials that showed no effect (ie no trend toward statistical significance) under the particular conditions constraining the practitioners and the trial inclusion criteria. The NHMRC's blanket statement 'homeopathy' may be easier to express, but is misleading.

In response to page 19 of the Draft Report:

People who choose homeopathy instead of proven conventional treatment may put their health at risk if safe and evidence based treatments are rejected or delayed in favour of homeopathic treatment.

Homeopathy should not be used to treat health conditions that are serious, or could become serious

- **The NHMRC has failed to mention the context of the state of general medical research**, as reported on the BMJ website [13]. Of 3000 treatments that have been evaluated by research 11% are rated as beneficial, 24% likely to be beneficial, 7% as a trade off between benefits and harms, 5% unlikely to be beneficial, 3% likely to be ineffective or harmful, and 50% being of unknown (undemonstrated) effectiveness'. The NHMRC could reasonably also clarify that people who choose 65% of the treatments that have been evaluated may put their health at risk if treatments with the other 35% (when indicated) are delayed. **Homoeopathy has been singled out**, when in comparison the homoeopathy trial evidence suggests a similar proportion with unknown effectiveness. The 5% of the population using homoeopathy therefore receive greater attention from the NHMRC than the majority who use conventional medical care, a context that probably affects the whole population.
- Controlled trials describe average outcomes obtained from a group of people, usually in regard to one or a few measured outcomes. They generally demonstrate that a proportion of the target group don't benefit. Consequently, whilst there is a need to consider the use of safe and proven treatments, many of the patients seeking homeopathic treatment have found that the conventional treatment relevant to them hasn't fulfilled those criteria. To the extent that homoeopathy is individualised health care, and that large observational studies suggest that between 75% and 90% of patients are satisfied with their homoeopathic treatment, the way the NHMRC has chosen to express its findings and beliefs about homoeopathy runs contrary to these patients' experience: this stance is likely to discourage patients from disclosing their use of homoeopathy to other health professionals.
- While homoeopathy is not and should not be the first choice of care for patients with serious health problems, there are many published cases of patients with serious health conditions recovering under, or assisted by homoeopathic management, often where regular medical care has failed

> to assist them. Any health condition, including apparently good health can become serious. A practical aspect is to clarify how serious a health problem is at any one time, and patients usually see a doctor for this purpose, and after trying what is offered they assess their options. Certainly it is the responsibility of all health practitioners to make ongoing assessments of the potential seriousness of the condition of every patient, and whether what they have to offer is the most advisable choice at the time, considering the individual circumstances involved. Higher levels of education are the most likely way to avoid mistakes concerning this decision, which is why lobbying by the Friends of Science in Medicine to keep the training of complementary therapists out of universities is counter to the community's interest. The need to be aware of and responsive to serious complications or conditions applies to all health practitioners, not just homoeopaths. By way of comparison, I don't think the community would be well served if the many reported episodes of medical misadventure led to the dictum that doctors shouldn't manage seriously ill patients.

Two out of three Australians use complementary therapies [14]. This increasing use is associated with consumers making decisions based on information from a variety of sources including personal experiences and those of friends or relatives relating to dissatisfaction with available medical treatments and the usefulness of the available alternatives; on occasion such alternatives are recommended by the medical profession where appropriate for the patient's particular circumstances. Patients may be better informed about these matters than their medical practitioners. Whatever the public policy outcomes of the NHMRC review of homoeopathy, the expanding evidence base supporting homoeopathy will continue to justify its increasing use in the community.

The NHMRC's Question 1: Is the draft Information Paper presented and written in a manner that is easy to understand?

The NHMRC report as been misinterpreted by members of the community and the media: The FoSiM for example appear to have misunderstood the report's findings. An open letter dated 8/4/14 on the FoSiM website [15], suggests a failure to understand the meaning of 'draft', as well as the fact that the NHMRC did not investigate the evidence concerning the prophylactic use of homoeopathy. They also seem to misunderstand this sentence (DIP Page 10):

'To be confident that the health benefits of homeopathy that were reported in some studies were not just due to chance or the placebo effect, they would need to be confirmed by other large, well-designed studies.'

FoSiM suggests that this means [15]:

'We note with satisfaction that you have rejected, ahead of time, predictable calls during the consultation period for more research into homeopathy before your recommendations could be accepted.'

Various media reports suggest that the authors haven't understood that the NHMRC found evidence of the effectiveness of homoeopathy, and that the quantity increases as time passes, but as yet is not convinced by the evidence, because of the quality, size and numbers of studies in any one condition. This is not surprising because news reporters have a habit of reporting 1 sentence out of 730 pages of a report, and **the NHMRC has 'played into their hands' by failing to provide any context of the research environment from which to view these findings and their implications. This report does not make clear that lack of high quality evidence does not imply lack of therapeutic effectiveness, but quite possibly lack of research.** Research isn't 'manna from heaven'. It requires dedicated researchers, and in many cases considerable resources to generate trials of the kind that the NHMRC would rate as reliable, because of the larger numbers of patients involved, and the requirements to comply with a protocol. The homoeopathy industry is not well resourced with specialists, who can more easily collect together large numbers of patients who can comply with a single condition trial protocol, and who are willing to be randomised to a group that will not receive homoeopathic treatment. Friese et al [16] discuss the difficulties they had in organising a comparative group for their

homoeopathically treated otitis media patients which would satisfy practical and ethical requirements. Their experience is far from unique. **Quality criteria that have been evolved to assess potentially dangerous synthetic and expensive substances, have been applied here to relatively safe interventions.** A discussion of this issue would be appropriate in the context of public advice, bearing in mind also that in part the degree of rigor required to generate the evidence contributes to the cost of the medicine.

The NHMRC is dismissive of the work of hundreds of researching homeopathic clinicians and others involved in the decades of work they have reviewed. The NHMRC would be aware of the difficulties encountered in conducting medical research. The fact that the context of the wider medical research environment is ignored in its report, and that many references (describing the limitations of the type of assessment used by the NHMRC) were rejected by the NHMRC as out of scope [10,11,13,17-19], displays how divorced from daily practice and the consciousness of the general population this Evidence Based Medicine mentality has become.

Page 2 of the Draft Information Paper provides a suitable place to discuss the degree to which currently available health products and services are evidence based, and to reference those that have been subjected to some investigation as reported by the BMJ [13]. Such a discussion would provide a suitable context for the findings in this investigation of homoeopathy, and is essential to assist the community in understanding how research is used and applied more broadly in the medical community. It would also be appropriate to mention the recent Cochrane summary of the evidence supporting influenza immunisation [20], which has been recommended by the NHMRC for many years in spite the weak supporting evidence for this treatment. The recent report on Relenza and Tamiflu [8] could be mentioned (as well as the $192 million spent on it by the Australian Government), to provide the public with the context of how quality evidence gathering is applied by the NHMRC.

1. Complementary Health Care Council of Australia

2. contact the writer at nicgoodman@optusnet.com.au

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