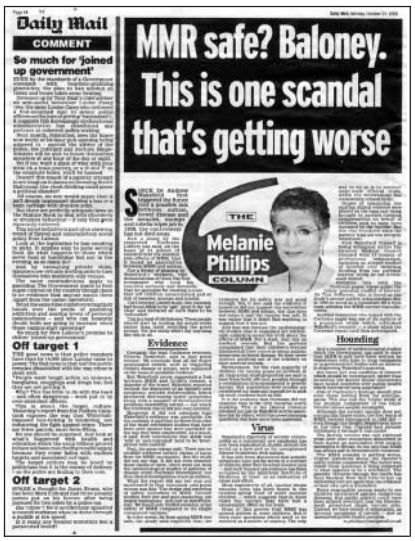
Why can't the *Daily Mail* eat humble pie over MMR?

The recent publication of a Cochrane systematic review concluding that there is "no credible evidence" of a link between the measles, mumps, and rubella (MMR) vaccine and either inflammatory bowel disease or autism provoked demands that the British tabloid newspaper the *Daily Mail* apologise for its role in promoting the MMR-autism scare (http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004407/frame.html). Instead, on 31 October, the paper published a feature by leading columnist Melanie Phillips insisting that claims that MMR was safe were "a load of old baloney" (www.melanie-phillips.com). Phillips proclaimed that, far from having received the "all-clear," the "MMR scandal" was "getting worse."

The otherwise unanimous verdict of the media was that the Cochrane review—following a series of studies coming to the same conclusion—confirmed that the scare launched following the now notorious Andrew Wakefield *Lancet* paper in 1998 was finally over (*Lancet* 1998;351: 637). Phillips's defiant article stands as a symbol of the woeful role of the media in the course of the MMR controversy.


Daily Mail

COMMENT

So much for 'joined up government'

MMR safe? Baloney. This is one scandal that's getting worse

THE Melanie Phillips COLUMN

Evidence

Hounding

Virus

Off target 1

Off target 2

It is true that the MMR-autism scare did not start in the press. Both a reputable London teaching hospital and a prestigious medical journal allowed the scare to start. Yet, once Wakefield decided to go public with his anti-MMR campaign, the media played a major part in promoting the scare. Phillips's response to the Cochrane study follows the familiar themes of numerous anti-MMR articles over the years, including several by Phillips herself.

Phillips's article is scientifically flawed. She seems to misunderstand the nature of a systematic review and to misinterpret any criticism of studies of MMR safety, or any expression of uncertainty about their conclusions, as a vindication of Wakefield's case. She echoes the mantra of anti-MMR campaigners that epidemiological methods are not suitable to discover an association between MMR and autism, when this is precisely the point of such methods. Indeed, this is why Wakefield explicitly invited epidemiological studies in his *Lancet* paper—only to repudiate this approach when one study after another failed to support his hypothesis.

In endorsing Wakefield's claims, Phillips ignores the overwhelming weight of scientific evidence to the contrary. She insists that his discovery of "autistic enterocolitis" has been replicated around the world and that "vaccine-strain" measles virus has been found in cerebrospinal fluid samples from autistic children, though she fails to mention that these few studies have been carried out by Wakefield or his collaborators and are universally dismissed by reputable authorities.

Two days after publication of her *Daily Mail* article, Phillips was criticised by doctor and columnist Ben Goldacre, in a piece in the *Guardian* newspaper. This week (8 November) the *Guardian* gave Phillips a right of reply, in which she defended the stance of her *Mail* article.

Phillips appears to be captivated by Wakefield's self professed status as a maverick and crusader against the establishment. His posture of martyrdom and victimhood seems to have a particular appeal for Phillips, whose polemical style provokes much animosity. The price of this self indulgence (Phillips is one of Britain's best paid journalists) is borne by the real victims of the MMR-autism fiasco. These are parents anxiously facing decisions about immunisation and parents of children with autism who carry an unwarranted burden of guilt over having had their children immunised.

Phillips is one of many journalists (by no means confined to the tabloids) who have endorsed the anti-MMR campaign. They have provided a voice for middle class anxieties about environmental threats and for the distrust of established sources of authority in science, medicine, and politics that have led some parents to reject MMR. Some journalists, writing as celebrity parents, have followed the principles of the "journalism of attachment" popularised in recent military conflicts. This requires a high level of emotional engagement but no specialist knowledge of the subject (specialist medical and scientific correspondents have generally rejected the MMR-autism link). Although autism has become fashionable in the media, a condition characterised by difficulties of communication remains uniquely terrifying to those who live by the word. For a profession renowned for its sociability, children for whom language and friendship are problematic are a source of potent fears.

British journalists have a poor record on MMR and, indeed, on autism

With a few notable exceptions—such as Brian Deer, whose work for the *Sunday Times* and Channel Four helped to discredit Wakefield's *Lancet* paper—British journalists have a poor record on MMR and, indeed, on autism. While certain journalists have lionised Wakefield, real scandals—such as the recent death of an autistic boy from Britain undergoing mercury chelation therapy in the United States, or the inadequacy of respite services revealed by the conviction of a 67 year old mother for killing her adult autistic son when she could no longer cope with his violent behaviour—have largely been ignored (www.spiked-online.com). If children die from measles, the MMR scandal may indeed get worse.

Michael Fitzpatrick *general practitioner, London*
fitz@easynet.co.uk

Competing interest: MF is the author of *MMR and Autism: What Parents Need to Know* (Routledge, 2004).

Items reviewed are rated on a 4 star scale (4=excellent)

The US Public Broadcasting System and Time Magazine take on global health

A week of events including the television series *RX for Survival: A Global Health Challenge*, broadcast on PBS from 1 to 3 November and available on VHS and DVD
www.pbs.org/wgbh/rxforsurvival/index.html

Rating: ★★★

With the discovery of penicillin in the 1940s, scientists were confident that "humanity had finally won" in the war with microbes. Infectious diseases that had devastated the globe for centuries were in abeyance by the 1970s, and most people in developed countries did not fear the old scourges of smallpox, cholera, plague, malaria, and tuberculosis.

Since then, however, the world has been shocked by the rise of new plagues such as HIV/AIDS and SARS (severe acute respiratory syndrome), haemorrhagic fevers arising from Ebola and Marburg viruses, and the threat of avian influenza. But many old plagues still devastate developing countries, destabilising the global community and unnecessarily killing millions. In response, rock stars, developmental economists, billionaire entrepreneurs, and even occasional governments now recognise the need for commitment to global health.

Last week the US Public Broadcasting System (PBS) put out a six-part series entitled *Rx for Survival*, dedicated to explaining the historical successes and new challenges in infectious disease control. *Time Magazine* simultaneously staged a global health summit in New York that attracted former US president Bill Clinton, Microsoft founder Bill Gates, Jeffrey Sachs, director of Columbia University's Earth Institute, Peter Piot of UNAIDS, the World Health Organization's Jim Kim, and (by video) U2's Bono.

In addition, a special *Time* issue on global health highlighted the "heroism" of 18 people working at the community level to take on poverty and global health. Less publicised, a group of international health leaders met at Yale University as part of the Oxford Health Alliance to increase global attention to the epidemics of chronic diseases such as diabetes, cardiovascular disease, and cancer. These events put sharp focus on the need for strong collective action, and they pointed out in clear terms that we have the historical knowledge and the economic means to make an immediate difference in these global problems.

TABITHA JACKSON, COURTESY OF WGBH

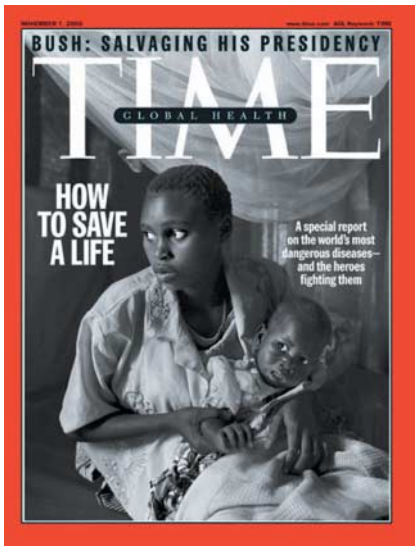
The series' message was that cooperation is vital for health in the developing world

The PBS series, narrated by Hollywood actor Brad Pitt, began with in-depth coverage of the current polio campaign, focusing on the last remaining pockets of resistance and the last residual cases of acute flaccid paralysis. David Heymann, WHO polio campaign director, remarked that as a result of the most sweeping public health campaign in history, we might soon see the last cases of polio. In 1977, after thousands of years of human suffering, we saw the last case of smallpox in Somalia, eliminated using ring vaccination and creative surveillance to isolate cases and prevent spread. But these two eradication campaigns are different, and the story behind them, told by smallpox warriors D A Henderson and William Foege, revealed what has to be done to eradicate polio. One must overcome not only huge logistic problems, but also political and religious resistance and misguided complacency.

In Nigeria, rumours that Western countries included sterilising chemicals in the polio vaccine caused resistance to the campaign, and polio then spread to other sub-Saharan African countries; in India, devout Muslims preferred to trust in god rather than Western-sponsored campaigns to protect their children; in affluent US communities, well off mothers refuse vaccines because of potential harm to their individual children. All of these resistant cases are targeted as part of a collective enterprise requiring cooperation and commitment to universal immunisation, just as many other diseases require cooperation and commitment for the greater public good.

An episode entitled "The Rise of the Superbugs" pointed out the clear, imminent danger we face with resistant organisms, especially tuberculosis, and the lack of new antibiotics in the drug development pipeline. A perfect microbial storm may be ahead, with poverty, health systems failures, and lack of investment in therapeutics all coalescing to threaten not only the poor of the world, but all persons affected by these organisms. Paul Farmer and Jim Kim of the non-governmental organisation Partners in Health have shown how, despite abject poverty, multiple-drug resistant tuberculosis is confronted and controlled through creativity and dogged determination. These bugs will never go away by themselves.

In an episode on "Delivering the Goods," 21st century technologies were shown to extend the reach of good medicine through proper management and individual commitment. Riders for Health, an NGO that provides cheap transportation for medical care and medicines, delivers health care to the most remote places in Africa. In west Africa, ivermectin is distributed as a cooperative effort between Merck, the World Bank, the Carter Center in Atlanta, and others to halt river blindness in its tracks. In Botswana and Uganda, the pan-African disaster of HIV/AIDS has been slowed through good medical practice and increased financing.



Without such interventions, life expectancy can be expected to go down, and the costs of inaction will overwhelm economies and health systems. Already, 80% of all hospital admissions in sub-Saharan Africa are for AIDS related illness. The money is available, prevention and treatment options are well established, and now commitment, funding, science, and human resources can make a difference.

Although the series referred to the epidemic of obesity as an emerging global health threat in both affluent and emerging economies, it made no mention of the enormous burden caused by tobacco, the high burden of disease resulting from mental ill health, and the growing impact of physical inactivity and poor diet on health equity. The Oxford Health Alliance represents the most visible recent effort to focus on these problems.

The PBS series showed that cooperation is vital, and that the private sector, governments, and media are all needed to make a difference in global health. The Time Global Health Summit was heavy with celebrity, bringing, as Bono put it, the bright lights to the problem. People like Bill and Melinda Gates bring resources, but governments must bring leadership. Global health is necessary as a moral and economic imperative, and now, more than ever, it has been placed on the international agenda for all.

Thomas E Novotny *professor in residence, epidemiology and biostatistics, and education coordinator, University of California at San Francisco Global Health Sciences, USA*
TNovotny@psg.ucsf.edu

Nelson's Surgeon: William Beatty, Naval Medicine, and the Battle of Trafalgar

Laurence Brockliss, John Cardwell, Michael Moss

Oxford University Press, £45, pp 236
ISBN 0 19 928742 2

Rating: ★★★

The 200th anniversary this year of the Battle of Trafalgar has sparked new life into the subject of Britain's maritime history. But the work of naval surgeons has rarely been explored in any great detail. Signing up for the navy was often seen as a route by which young men with an interest in surgery and a basic qualification provided by the Company of Surgeons could gain experience before furthering their career in private, civilian practice. For others it was the only opportunity to practise, their level of proficiency being deemed inappropriately poor to be let loose on the public.

At a time when surgeons were not required to have studied medicine, they were none the less usually from more privileged backgrounds than most of the crew and they resented their lowly standing, often being forbidden from dining with the officers and, if present, the ship's physician. The career structure of the naval surgeon appeared to have been a precarious one, depending as much on the patronage of the captain of the vessel they were assigned to as their technical skill and judgment.

One such example is that of Sir William Beatty, an Irishman whose career got off to an inauspicious start when he fell foul of Commander Lord Augustus Fitzroy, who accused him of bowing sarcastically. A court martial rejected the case as trivial, effectively ending Fitzroy's career. Working for the industrious Captain Henry Digby, Beatty enjoyed better fortune and his excellent health statistics brought them both to the attention of Admiral Nelson.

In 1804 Nelson appointed Beatty to the HMS *Victory*, the flagship of the British fleet. At Trafalgar one year later, Beatty was to distinguish himself, as 96 of 102 casualties—including nine of the 11 amputees—survived. The average death rate from amputation at the time was about 33%. Beatty was unable to save Nelson, however, who died in battle.

Based loosely on the life and career of William Beatty, *Nelson's Surgeon* is a study of naval surgery during the Napoleonic wars. In a rigorously researched piece of work the authors paint a vivid portrait of the hellish brutality and occasional tedium of life on board a vessel of Nelson's fleet. They imply that a critical factor in the success of the British fleet was that its sailors were healthier than their French counterparts, largely owing to advocates of preventive medicine such as Beatty. The class politics and struggle for surgeons to have their skills recognised permeate this work, hinting at the seething resentment that lay at the interface between physicians, surgeons, and the Royal Navy.


WELLCOME LIBRARY, LONDON

Beatty: excellent health statistics

Graeme Glass *senior house officer in plastic surgery, St George's Hospital, London*
graemeglass@hotmail.com

FILM

3 Needles

Directed by Thom Fitzgerald
Shown at the London Film Festival on 31 October and 1 November

Rating: ★★★

The Canadian film *3 Needles* is a challenging attempt to analyse the role of the West in causing disease and poverty in the developing world. Set in South Africa, China, and Canada, it weaves together three stories with the common theme of blood, religion, and sacrifice.

It begins in South Africa, portraying the rituals of male circumcision and young adolescents' entry into a new world of manhood and adult responsibilities. Into this climate of deep-rooted cultural beliefs comes an idealistic young nun-nurse (played by Chloë Savigny), who believes that prayer can make the world a better place. She seeks to convert Africans dying from AIDS to Catholicism and puts her own life at risk in the process. The story is told against a background of exploitation by rich farm owners, local corruption, and the belief that having sex with a virgin can cure HIV infection, which in turn leads the disease to be spread further among young women and children.

China is the setting for the second story, where poor farmers in a remote village are paid money to donate blood, which is then transported to the West to be made into blood products. Poverty and need force residents to sell even their young children's blood.

The film is timely reminder that AIDS is still with us

In the third story a Canadian porn actor tries to forge an HIV test by using his grandfather's blood. When he is found out, his mother (played by Stockard Channing), in a desperate bid to pull her family out of poverty, tries to exploit insurance companies. In their recklessness both mother and son spread HIV, without any feelings of guilt or remorse.

The triad of ignorance, poverty, and poor health that *3 Needles* portrays perpetuates itself in a vicious cycle, resulting in death and destruction of whole civilisations. The messages of the film are clear: religion is not the answer; salvation cannot come through prayers alone; educating people about how HIV is spread and to practise safe sex is the only effective way of combating AIDS.

This film is a timely reminder that the AIDS pandemic is still with us, especially in Africa. For example, a recent census showed that 38% of adults in Botswana are infected with HIV. However, *3 Needles* does suffer from a lack of real character development; most of its characters have a symbolic role, representing whole nations. Despite this, and the lack of a clear narrative link and the film's occasionally confusing structure, it is worth watching for its powerful global health message.

Khalid Ali *senior lecturer, University of Sussex*
Khalid.ali@bsuh.nhs.uk

PERSONAL VIEWS

In Pakistan's earthquake zone global relief has so far failed its test

At over 1.83 metres tall and a former soldier, I do not cry easily, yet I am certainly crying now. The reason? Frustration following Pakistan's earthquake, perhaps the biggest disaster to strike this planet in my lifetime and something that the world's largest aid effort seems powerless to relieve.

I am in the Neelam valley, east of Muzaffarabad, helping to establish two small field hospitals. At the beginning the situation was hopeless, with large numbers of disaster tourists and their cameras, each seeking the one image that could establish their careers. Then there were the tedious meetings with aid agencies from around the world. The answer was clear. The people needed action, not discussion. Today I am in the little village of Panjgiran, in the company of Ahmad, a respected local in the throes of post-traumatic stress after losing his entire family in the earthquake. It was at 8 52 am on 8 October when, unexpectedly, the ground shot vertically upwards. Within three seconds it was all over with three million homeless and to date around 80 000 dead.

As I walk through the village, it is clear that there is no building intact. Ahmad shows me the pile of rubble that was once his house and the corner of the ruin from which he extracted his mother's corpse. We walk on, tears streaming down our faces, until we reach the school. This, too, has been flattened. Exercise books, once carefully written and cared for, now flap uselessly in the wind while opposite sits a group of four children. They are motionless; eyes open in incomprehension, orphaned that terrible day and, even now, with no one to care for them.

On we walk, the stench of death still lingering in the air, families grouped by the roadside, their most senior male member rising to greet me. I try to explain the problems; the endless, futile meetings, the lack of helicopters, and the size of the relief operation, but I can see my explanations landing on deaf ears. I see instantly what is needed. A tent for each family, a guaranteed food supply, and health care for their festering wounds.

I shake Ahmad by the hand, mumbling something useless such as "I'll do what I can," and find myself a lonely spot on the mountainside overlooking the valley. Beneath me I see a blue, winding, picturesque river, but all around there is evidence of landslides, both old and new. Below also is the road, now impassable. Another helicopter flies overhead, and another, and another, and another. I jump to my feet and wave my arms violently, trying to attract the pilots' attention. "Panjgiran!" I yell, "Come on guys, give us some of your load!" I cup my hands around my mouth and shout the village's coordinates, "North 34° 26' 47.3", East 73° 37' 12.3"!" But the helicopters carry onwards, clearly unaware that I even exist. So I sit down hard, childishly holding my head in my hands, as I realise that my efforts are wasted. Of course the pilots cannot see me, a tiny frustrated speck on the side of a massive 3000 metre mountain.

> There is no way of reaching every person other than on foot

The problem is clear although the solution is not. No matter how many helicopters may be donated, no matter how much money is given, the end point of delivery is a small, destroyed household perched on a mountainside. Even if a helipad does exist it is likely only to be able to take the smallest of helicopters. In my time here I have seen several machines sink beyond their axles into the clay-like mud. Physically, there is no way of reaching every person other than on foot or, perhaps, encouraging the householder to come down. If they can, of course, with their festering wounds, neglected fractures, and half-starved bodies. Only yesterday I saw a 12 year old boy who had dislocated his right hip during the earthquake. It had taken him more than a day to reach me, carried by his father. His mother and his sister were long since dead, one beheaded by their corrugated iron roof on 8 October, the other smothered by sliding rubble.

In the distance I see the helicopters deliver their cargo to a military base and I know that that is the end of the line for the aid. There are few smaller helicopters to deliver the items further up the mountainside. I have also heard that there is a cash crisis and that relief flights may be suspended within the next few days. So I sit on my mountainside feeling helpless. Mad ideas flit through my mind. Employ 10 000 mountain guides to walk every ridge in Kashmir, or mobilise every soldier, sailor, and pilot in the globe. Yet even then only the surface would be scratched. At 8 52 am on 8 October global relief began its test; to date, it has failed. However deep we all dig, the end point is the 12 year old boy, or Ahmad, or the millions like them, stranded on remote mountainsides in the wilds of Kashmir. Tears of frustration are no help. It is just that crying is all I can think of right now.

Richard Villar *consultant orthopaedic surgeon, Wellington Hospital, London*
rvillar@uk-consultants.co.uk

SOUNDINGS

Just listening

A few years ago I helped with a door to door survey on a grotty council estate. I had been drafted on to some *ménage à trois* collaboration (academic, service, and voluntary sector), and we were heavy on hearing local voices.

I had helped design the survey and done my utmost to ensure that it was evidence based. We especially wanted to include refugees, chain smokers, single parents, people who didn't speak English, the unemployed, people who sell sex, those addicted to illegal substances, etc, so that we could design accessible and culturally congruent services at the interface between health and social care.

I parked my car two miles away and made my way across a motorway bridge, through an alley, past burnt out vans and abandoned junk, to the far corner of the estate, where my target block of most-deprived flats lay.

Times have moved on. You can now explore the perspective of society's have-nots without setting foot outside your ivory tower. Just send them the URL of the Department of Health's latest listening exercise, "Your health, your care, your say" (www.nhs.uk/yoursay/). Your sample can simply click a radio button to indicate whether they would prefer to receive "Information, support and advice on tackling drug use," "An NHS book on taking care of your own health," or "Routine physical examinations for anyone who wants one."

Their responses constitute, in the government's own words, "democracy in action." They will—presumably—be collated and used to prioritise community based service provision for the disempowered and socially excluded. Because thousands of people have clicked their way through the survey, the data generated will be robust and reliable—or so the government thinks. Because people have been asked for their views directly, rather than professionals or voluntary sector advocates speaking on their behalf, service users are expected to be more empowered.

An elderly woman has just been given a suspended prison sentence for suffocating her severely disturbed and violent 36 year old autistic son. She had been his devoted carer for 30 years, and had written repeatedly to social services pleading for help, with no meaningful response. Now there's a listening exercise that the government might like to reflect on.

Trisha Greenhalgh *professor of primary health care, University College London*