TV

Horizon: Does the MMR Jab Cause Autism?

BBC 2, 29 May at 9 pm

Rating: ★★★☆

BBC

MMR: still an emotive issue, but have parents' attitudes started to shift?

Oh no. Surely the MMR (measles, mumps, rubella) vaccine story has been hammered to death. Why is the BBC now picking through the remains of yesterday's news? At our baby clinic on Tuesday afternoons we still have concerned mums and dads, but most are happy to go along with our advice. Like most doctors, I have trotted out my own unsystematic interpretation of guidance from experts, government departments, and advice leaflets. But, I should confess, there was still a tiny voice in the back of my mind wondering if there might still be a grain of truth in the story about a suggested link between autism and MMR.

Depending on the day, I watch programmes about MMR with a varying balance of natural cynicism and scientific acceptance. The BBC is usually fair and well researched, so I tried to watch this programme with an open mind. The *Horizon* verdict: there was nothing in the MMR and autism story and many children have suffered unnecessarily from the outcome of the widespread publicity. The programme makers presented both sides in a balanced and relatively unemotional manner.

This was difficult, because MMR is such an emotive subject and we all naturally sympathise with distraught parents searching for the cause of their children's autism. Autism is an incredibly difficult condition for a family to cope with and I cannot blame any parent convinced that Andrew Wakefield—the gastroenterologist who first mooted the link between autism and MMR—had the answer. After all, we have precious few other explanations. It is such a shame that what appears to have begun as a genuine hypothesis got lost in the media hype, and scientific debate became such a public battlefield.

As a doctor, I found the endless shots of needles, syringes, and childhood injections in *Horizon*'s foray into this battlefield a little offputting, and I am sure parents found it difficult too. Our epidemiology colleagues, often pictured as a rather dull and worthy lot, would have enjoyed their portrayal as the good guys, the cavalry coming over the mountain armed with conclusive evidence. There were also some damning indictments of anecdotal medicine: soundbites used by the anti-MMR lobby that would make any scientist cringe—"forget epidemiology, look at the children" or "I don't have time for statistics when I see a sick child." But many parents might have found such arguments seductive. The programme quoted unpublished evidence to support its stance, and it could also have been criticised for this.

Television is about a good story, however, with lots of twists and turns, and this programme was no exception. It began with moving pictures of an autistic boy called James. It ended with this patient's father, himself a general practitioner, forthright in his support of MMR, and with Simon Murch, one of the co-authors of Andrew Wakefield's original *Lancet* paper (*Lancet* 1998;351:637), changing his mind about the purported MMR-autism link.

I am still not sure why the programme makers waited until now to do the story. The world has moved on and there are more topical medical controversies. Also, parents' attitudes have changed. It is a long way from Northern Ireland to South Devon and we don't have many happy hippies in sandals and flowing print skirts in our city practice, but my patients are genetically programmed to be suspicious of government. Interestingly, however, attitudes to immunisation have altered in the past few months. What has made the difference is a recent epidemic of mumps. A fascinating natural experiment has left the older generation immune, the younger children mostly immunised, but those in their early 20s with neither natural nor evoked immunity. And so mumps has been raging through our young adults. Now we have queues for immunisations, and the patients are chasing us, not the other way around. Recently I also saw a case of measles.

We have come full circle now, and immunisation rates are creeping back up. But it is neither scientific papers nor medical journals that have made the biggest and most lasting impression. It is witnessing the suffering of others, and our emotional response to illness. Mums and dads are more likely to have their children immunised if they see what happens when others are ill.

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Narrative Research in Health and Illness

Eds Brian Hurwitz, Trisha Greenhalgh, Vieda Skultans

Blackwell and BMJ Books, £45, pp 456
ISBN 0 7279 1792 7

Rating: ★★★☆

Is "narrative" a story, a drama, or a life? Is it a general class of text? According to this collection, narrative can be any of these things—and more. This raises an interesting question. Why do researchers focus on "narrative" when the meaning of the term is so ambiguous and variously interpreted?

The main motivation of this type of research seems to be to counter the social fragmentation that goes with specialisation. Specialisation creates communication barriers between experts and non-experts and also between different tribes of experts. Narrative bridges the first divide by allowing health professionals and researchers to connect with patients and research participants on the common ground of natural language. This is part of a growing humanistic tendency in medicine, which is welcomed by those who are long weary of medicine's scientific posturing. Narrative bridges the second divide by providing a theme common to different academic disciplines. This has led to productive dialogue between (for example) medical sociology, bioethics, and the medical humanities.

The "narrative turn" in medical research has thus been a boundary crossing exercise; and this collection of papers, together with its antecedent volume, *Narrative-Based Medicine: Dialogue and Discourse in Clinical Practice* (BMJ Books, 1998), is a record of some of its research output. Both collections warrant close attention from people who seek to understand the narrative turn in medicine. Those who want to learn how to do narrative research should perhaps look elsewhere, however. If ambiguity about the meaning of the term narrative has permitted the bridging of divides, the bridge is now straining. The term has become a category without boundaries and has thereby come to represent many different ways of meaning. The less clear the boundaries, the more baggage it collects. If this trend continues, the bridge may collapse. This may not be such a bad thing, however.

Narrative increasingly seems to be the flagship of a growing field of research that has yet to become conscious of itself as the study of language as it relates to health, illness, and health care. The study of stories is the most natural and appealing route into the study of language generally. This explains the fixation on "narrative." In order to reason about language more generally, however, researchers need to differentiate between different ways of meaning. Collapsing them into super-categories is of little use to the practical task of analysis. Moreover, it is increasingly apparent that we need a theory of language that will provide researchers with a common terminology for describing linguistic phenomena. Without this, the meaning of basic terms will continue to differ, and the research will continue to be incommensurable. Useful theories of language exist (such as S Eggins's *An Introduction to Systemic Functional Linguistics*, 2004), and they provide language explorers with invaluable tools as well as a lingua franca.

Narrative Research in Health and Illness may mark the limit of an arc in the "narrative turn." Looking back, we can see that the term narrative has been productively overworked. Looking forward, we can surmise that medicine may be developing a linguistic subspecialty, as did education last century. This is because technicality, as well as ambiguity, has its uses.

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Using Cost-Effectiveness Analysis to Improve Health Care: Opportunities and Barriers

Peter J Neumann

Oxford University Press, £21.50, pp 224
ISBN 0 19 517186 1

Rating: ★★★★

Just when you thought it was safe to dismiss cost effectiveness analysis as another dry and boring topic, of interest only to geeky economists or hard hearted bureaucrats, a book has emerged that makes the subject unexpectedly compelling.

The Harvard academic Peter Neumann passionately and eloquently articulates why we should all take more of an interest in how our health system gets value for money from medical treatments and technologies. More importantly it shows why the country with the world's biggest and most dysfunctional health economy, the United States, has been so slow to embrace this tool for rationally making decisions about money and medicine.

"As health spending in the United States soars past $1.5 trillion," Neumann explains with characteristic drama and simplicity, "cost effectiveness analysis lies at the heart of perhaps the ultimate health policy question: how can we get good value for our money?"

Put crudely, cost effectiveness analysis is a way of working out the cost per effect from a drug, prevention strategy, device, or procedure. It's a set of equations for calculating how much money it will require to produce an extra year of human life, using statins, or breast cancer screening, or the Mediterranean diet.

Despite its eye glazingly tedious title, the book will have widespread appeal. It is accessible, clear, and unpretentious. It has humility and warmth rather than the hubris and chill you might expect from an academic text originating in Harvard University.

Chapter by chapter the reader learns what cost effectiveness analysis is, why it is important to policy makers, health professionals, and the public, and who does it well and who doesn't. Although the book has a lot of good, dispassionate scholarship, it also contains analysis and editorial comment, spread throughout. For the US based Neumann, cost effectiveness analysis is a way "to bring a structure and order and scientific reasoning to an unruly and inequitable health care system."

In some ways the book seems to have been written with a sense of exasperation that the United States has been so slow to take up this tool, whereas many countries in Europe are well advanced in how they make decisions about what gives value for money and what doesn't. Yes, cost effectiveness analysis is an uncertain science; but while it is maturing in many places around the world—notably Australia—it hasn't even begun to crawl in most parts of the United States.

Why is this so? The fear in the United States is of course the R word: not reds, but rationing.

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

PERSONAL VIEW

Exercise or relaxation after stroke?

I had always enjoyed the occasional hill walk, but it was only when I joined the local mountaineering club that I discovered how regular physical exercise really does improve health and quality of life.

When I wasn't in the hills I was training to be a geriatrician, with an interest in stroke. I couldn't help wondering whether the prolonged periods of immobility that often occurred after stroke must reduce both aerobic fitness and muscle strength and that stroke related disability might be reduced if physical fitness could be improved. We did a Cochrane systematic review on physical fitness training after stroke. We found only a small number of randomised trials of physical fitness training after stroke. The data were insufficient to draw any definite conclusions, although there were hints that mobility might be improved.

So, with funding from the Chief Scientist Office of the Scottish Executive we set up a randomised trial to compare a 12 week programme of thrice weekly physical fitness training with an "attention control" intervention of relaxation. We invited ambulatory stroke patients who had completed their rehabilitation to participate.

The trial is ongoing and we cannot yet comment on the relative benefits of the two interventions, but we have been struck by the strong and persistent anecdotal evidence of psychosocial benefits in both groups. These are manifested in various ways. For example, about halfway through the 12 week programme, the patients started to give the instructor fresh flowers, chocolates, and knitted scarves and hats. On the final day of the classes the instructor received so many gifts that she needed a taxi to take them all home. When I attended one of the classes recently I was greeted by one of the patients, who gave me a plastic carrier bag containing six bread rolls and six freshly baked scones from his bakery. This was his way of thanking me for setting up the classes. I looked around the hall and noted that every patient in the group had also been given a similar bag. Our instructor had been given a "bumper" bag containing six fresh fudge doughnuts in addition to the rolls and scones.

These gifts are just one manifestation of the gratitude shown both to the instructor and the fellow participants. What are the reasons for such overt signs of thanks? A poem written by one of the patients who attended one of the relaxation classes is illuminating. It included the lines, "The company of others has made me very happy," "The things we have learned have been very good," and "The lady that does run the class/To this gem we do raise a glass/Her gentle manner and soothing ways . . ." Many other participants said that the classes enabled them to "get out of the house" and to meet other people "in the same boat." Our extensive battery of outcome measures, which focus mainly on physical benefits, is unlikely to capture the full extent of these apparent social benefits.

We were surprised by the strength of these feelings, but perhaps we should not have been. When I think about the benefits of mountaineering, it's not just about getting physically fit, or even about the personal satisfaction of learning a new skill, but from the deep friendships that develop as a result of participating in the same activity and sharing experiences. People who have had a stroke are no different.

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Competing interests: GM is the principal investigator in a trial of physical fitness training after stroke, funded by the Chief Scientist Office of the Scottish Executive. She has also been invited to give a talk to geriatricians in Aberdeen about her research interests, including exercise after stroke. She expects to be paid expenses and possibly a small honorarium.

SOUNDINGS

Dangerous places

Risky destinations bother me less as I get older. Uzbekistan, a few months ago, felt safe. I heard the president was autocratic but relatively restrained in comparison with his neighbour in Turkmenistan, who has closed all regional hospitals and renamed January after himself.

A British passport, a World Health Organization schedule, and a police checkpoint outside our hotel gave me a sense of reassurance. The only time I felt anxious in Tashkent was when the lobby filled up with GIs. Hey, with y'all here, we're a target.

Nepal, several weeks later, was equally undemocratic. The king had seized power, apparently exasperated by parliament's failure to quell Maoist insurgency. Outside the royal palace, wary sentries crouched behind sandbags. On the streets, one blown-out shop was being repaired but otherwise life was normal. We checked our email in internet cabins to the sound of traffic tooting outside.

These two countries, north and south of the mountains, had much in common. Each had once been part of an empire whose influence could still be felt. In Tashkent we lectured through Russian translators. In Kathmandu schoolchildren wore English-style uniforms, and the local radio, playing requests, broke into "Happy Birthday."

Both places inspire heartache in the visitor. Uzbekistan has ancient, evocative architecture and markets almost unchanged since Marco Polo's day. Nepal has the Himalayas: the tourist flights at dawn are stunning, I'm told. These timeless countries could be magnets for visitors. Instead, men shoot one another.

Doctors in both places are wonderfully hospitable, but their official salaries are too small to live on. Compromises have to be made, and the rural poor lose out on medical care. Slowly you realise that this is normal across much of the world.

Neither country is in fact dangerous for foreigners. It is the natives who are at risk, especially the women. In Nepal one in 135 pregnancies ends in the mother's death.

When you check on the internet you can easily find data on a nation's population, economics, and oil reserves. Webmasters could help by making the maternal mortality rate a headline statistic. It is a clear indicator of how civilised a country is. Who knows, it might shame some autocrats into action.

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