

## MEDICINE AND THE MEDIA

# Cervarix: not the new MMR

The UK press may have learnt lessons from the MMR furore, though this hasn't stopped some papers from sensationalist stories about the HPV vaccines, writes **Rebecca Coombes**

We have known for more than a week that the Cervarix vaccine did not kill 14 year old Natalie Morton (*BMJ* 2009;339:b4032). But the sad death of the Coventry schoolgirl shortly after receiving the human papillomavirus (HPV) vaccine on 28 September presented a difficult test to the press in the United Kingdom.

The story had some of the hallmarks of the furore over the measles, mumps, and rubella (MMR) vaccine—a health scare also concerning a vaccine with a previously excellent safety record. Journalists had their fingers burnt over MMR, when they gave credence to the maverick doctor Andrew Wakefield and his later retracted evidence that the MMR vaccine might trigger autism. Perhaps wary of charges of gullibility, initial reports of Natalie Morton's death were restrained. "Don't panic" ran the *Daily Mirror* headline. Science friendly media agencies, such as the Science Media Centre, successfully fielded questions from the press and provided expert quotations.

The story moved quickly: on 1 October preliminary reports showed that Natalie had a large malignant tumour in her chest, which had caused her death. But some news desks were unable to shake the scent of a different story. On 4 October, in headline letters several inches high, the *Sunday Express* declared the "Jab 'as deadly as the cancer.'" These words were attributed to Diane Harper, who has been involved in clinical trials of GlaxoSmithKline's Cervarix and Merck's Gardasil.

Speaking to the *BMJ*, Harper, professor of obstetrics and gynaecology, community and family medicine, and bioinformatics and personalised

medicine at University of Missouri-Kansas City School of Medicine, said that she was extremely unhappy at the "horrible misconstruction" of her statements.

"I was not accurately quoted in either the *Daily Mail* or the *Sunday Express*," she said. "I never said that the 'jab was as deadly as the cancer,'

nor was the interview exclusive [as was claimed]. The journalists did not reveal the autopsy results of Natalie Morton at the time of the interview, leaving the statement that she died after her injection—

without clearing any inferences that the injection was the cause of her death, which we now know is clearly not the case."

Although Harper has reservations about the delivery of the mass HPV vaccination campaign, she is satisfied with the safety record of both vaccines. "The evidence base is quite adequate for both vaccines. The evidence for Gardasil does show a very small risk of adverse events. Both vaccines are in general safe for most women."

If the *Sunday Express* story was simply out and out inaccurate, minor errors elsewhere were also creating problems. These included reports directly after Natalie Morton's death that the whole HPV vaccination campaign had been suspended in the UK. This was not true; instead there was a delay in getting replacement supplies of Cervarix after the batch that included the vaccine used on the 14 year old was quarantined as a precaution.

However, Tom Sheldon, of the Science Media Centre, writing in the *Guardian*, defended the right of journalists to ask questions. "Local radio stations have been inundated with emails from worried parents, some questioning whether to allow their daughters to have the vaccine. And it was natural to wonder whether the vaccine had anything to do with Natalie's death. Who wouldn't ask questions? That is the job of journalists, and to address the possibility of a link was legitimate."

But this was never going to be the next MMR, says Sheldon. "[Anti-vaccination] campaigners got barely a sniff of the action. We have learnt too many lessons from last time. Responsible, cautious scientists were everywhere this week, offering measured, evidence based information."

This measured tone didn't filter through to the review section in the *Sunday Times* of 4 October, in Rosie Millard's 1000 word feature entitled "What has this jab done to our girls?" The former arts correspondent spoke to families involved in a class action suit against GlaxoSmithKline. The parents claim that their children had an adverse reaction to the HPV vaccine. The feature began ominously: "A year ago Rebecca Ramagge was a happy, sporty teenager. Today she's a 13 year old crippled with chronic fatigue syndrome who has been laid up in bed for seven months."

Although Natalie Morton died from a tumour, not the vaccine, said Millard's article, "privately some NHS doctors are of the view that the injection might well have been a catalyst." A sceptical GP quoted in the article was not a vaccination expert but the journalist's brother. "A giant vaccination programme is the sort of tacit agreement that



## Sunday Times coverage of Natalie Morton's death

sexual activity for teenage girls is all right," said Richard Millard.

The GP, writer, and broadcaster Phil Hammond is not surprised at some of the more over the top coverage but questions why the government wasn't quicker off the mark.

"The only way to counter scare stories is to have charismatic communicators to shoot them down quickly. Andy Burnham should have led the charge with the HPV vaccine but has been slow out of the blocks."

Hammond also questioned why the government didn't quash any conspiracy theories and publish the assessments it made of the two HPV vaccines. "If you don't publish in full why you made a particular decision at the time, it smells as if you're trying to conceal something. The Tories have made some capital out of this, as well as the press."

No evidence exists that Gardasil is any safer than Cervarix. An article in *JAMA* in August (2009;302:781-6) reported the results of safety surveillance in the first two and a half years since Gardasil hit the market and found 32 unconfirmed deaths. Two further deaths have occurred in Europe, one in Germany and in Austria. The main difference between the two vaccines is that Gardasil also protects against most forms of genital warts. It is also more expensive.

But some press stories suggested that cheaper also meant less safe, in the case of Cervarix. Amanda Platell wrote in the *Daily Mail*: "The tragedy of [Morton's] death highlights the scandal that this government went for [the] cheapest option." It was a line the *Daily Mail* had been peddling all week. Two days after Natalie Morton's death, the paper's columnist Allison Pearson stormed: "Why were we not told a deluxe version was available?"

But amid the more hot headed comments, Tom Sheldon is keen to emphasise how far health journalists have come since the MMR scare. In fact, he says, the "most frightening pieces of [anti-vaccination] rhetoric" he'd come across was from a doctor, Richard Halvorsen, in the *Daily Mail*, and not a journalist.

Says Sheldon: "I know of one health journalist who argued vociferously on Wednesday to stop her editors splashing with 'Ban this killer vaccine.' Google this headline and see who won."

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LEGAL TENDER Sheila A M McLean

# Live and let die

The case of Kerrie Woollorton rests solely on whether or not her decision to refuse lifesaving treatment was legally competent

The inquest into the death in 2007 of Kerrie Woollorton (*BMJ* 2009;339:b4070) has focused media attention on advance decisions (directives) or “living wills.” It has provoked some commentators to argue that giving legal standing to competently executed advance directives, as the Mental Capacity Act 2005 does, is a step too far onto a potentially slippery slope. (It is worth noting that this act does not apply to Scotland.) Although it is undoubtedly a tragic case, it is worthwhile to unpick what we can learn from it and what the main issues at stake are.

Ms Woollorton had apparently ingested antifreeze on up to nine previous occasions but had nonetheless accepted lifesaving treatment after these incidents. To complicate matters, she was also said to have had an “untreatable” emotionally unstable personality disorder. The final twist in this complex story was that a few days before her death she had drafted an advance statement indicating that she did not wish to be treated should the same circumstances arise in the future, even if she called an ambulance. Rather than being treated, she wanted to die in a situation where she was not alone and where comfort care was available. A document containing a rejection of treatment was presented by Ms Woollorton on admission to hospital when she was still conscious. Presumably this document had been executed in line with the legislative requirements, and it was apparently accepted as valid.

What can be drawn from this case? Firstly, even though Ms Woollorton had previously accepted lifesaving treatment after ingesting antifreeze, no legal inference can necessarily be drawn from this that she would—had she been thinking clearly—have accepted treatment on the final occasion. In other words, even if she had “changed her mind” in the past, objectively she had the right to make a different decision on this occasion.

Secondly, as she was able to make a contemporaneous refusal of treatment

on admission to the hospital, her doctors were legally unable to provide treatment, and the existence or not of a binding advance directive was legally irrelevant. This, of course, depends on the presumption that she was legally competent at the time of the refusal. The fact that she apparently had some form of personality disorder is not in itself persuasive evidence that she was not competent. It is well established in law that even the presence of mental illness is not a bar to the presumption of competence (*Re C* (adult: refusal of medical treatment) [1994] 1 All ER 819). The Mental Capacity Act 2005 clarifies that a person is legally incompetent if he or she is unable to understand the information relevant to the decision, to retain that information, to use or weigh that information as part of the process of making the decision, or to communicate his or her decision (whether by talking, sign language, or any other means). The conclusion of Ms Woollorton’s treating physician, which he apparently took some pains to have verified, was that Ms Woollorton did not fail the competence test outlined in the Act and was steadfast in her wish to reject treatment.

Of course, it also seems that she may have been depressed, and this possibility has also raised some concerns. Should a person who is depressed have his or her decisions respected, especially when the consequences of so doing are as grave as they were in this case? This is a difficult question to answer, but some implications may be derived from other examples. Take the case of a person who rejects life sustaining treatment, albeit in different circumstances. One such situation arose in the case of *Ms B* (*Ms B v NHS Hospital Trust* [2002] 2 All ER 449). Here, a woman had become tetraplegic and depended on a ventilator. Her mental competence had previously been in doubt, but it appeared that she was competent at the time she requested the removal of the ventilator. Her treating doctors declined to agree to this and attempted to encourage her to agree to an alternative regimen that would involve weaning her



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off the ventilator. It seems plausible that *Ms B* could well have been depressed by her situation, yet the court ultimately upheld her right to refuse ventilation and even levied a small fine on the doctors involved for failing to comply with her wishes.

Assuming that *Ms Woollorton* was indeed legally competent, the existence of the advance directive was, as we have seen, irrelevant and is needlessly confusing in this case, which in essence is only about a straightforward refusal of consent by an adult person who is deemed legally competent. Simply put, a doctor who imposes treatment in the face of a competent refusal would be guilty of assaulting the patient.

However dreadful it must be for healthcare professionals to watch a person who could be saved die because they have declined available treatment, they have no alternative but to do so in these circumstances. The recent legislation does not change this position. Of course, had *Ms Woollorton* arrived at hospital in an unconscious state and with no advance directive, the chances are that doctors would have done everything in their power to save her, and this would have been justified by the legal doctrine of necessity. Had she arrived unconscious but with an applicable advance directive, equally no attempt at treatment would have been lawful.

However, neither of these situations arose. *Ms Woollorton* was adult and apparently competent and able at the relevant time to reject treatment. The question, therefore, is not about advance directives but about whether or not her decision was in fact legally competent. If she was, then refusal was her right and, as such, had to be respected.

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DOCTORS AND HUMAN RIGHTS John S Yudkin

# The Israeli Medical Association and doctors' complicity in torture

The IMA needs to take well documented allegations more seriously than it has done so far

A recent *BMJ* news report outlined the reasons behind the call by 725 doctors from 43 countries for the former chairman of the Israeli Medical Association (IMA), Yoram Blachar, to step down as president of the World Medical Association (WMA).<sup>1</sup> The doctors' petition, addressed to Edward Hill, chairman of the WMA Council, documented a series of reports, going back to 1996,<sup>2</sup> of cases in which Israeli doctors have been accused of complicity in torture and where the IMA had failed either to respond to or fully to investigate the charges. Although Dr Blachar is no longer the IMA president and concludes his term as WMA president this month, the petition still raises important questions concerning the IMA's commitment to investigate and tackle possible complicity of Israeli doctors in the torture of prisoners and detainees.

In March this year I contrasted the powerful position statement on torture posted on the IMA's website with the failure of that body to respond to allegations in a report, published in May 2007, by the Public Committee Against Torture in Israel.<sup>3-5</sup> The report comprised detailed testimonies of nine torture victims and included names of medical personnel involved in their management in prison or referral hospitals, several of the personnel being IMA members.<sup>6</sup> The reasons for medical involvement varied, but the report included an account by a 29 year old man with a sacral ulcer. During his interrogation, he was intermittently tied over a four day period with all of his limbs arched back over a chair with a sharp edge to the seat. His testimony recounted visits to a hospital where he was examined, and after the intervention of his guards the doctors prescribed analgesics and returned him to prison. Six weeks later he was referred to a different hospital for investigation of the permanent foot drop that had subsequently developed.

The IMA, which fulfils not only the functions of a union and a guild, like the British Medical Association, but also the role of ethical overseer similar to that of the UK General Medical Council, had, by early this year, failed to investigate the allegations in the report.<sup>3</sup> However, in response to concerted pressure, the

chairman of the IMA's ethics board reported in March 2009, having contacted and spoken to "most of those listed," all of whom denied either any connection with the prison services or, in the case of the three who were so employed, any involvement in interrogations, torture, or medical approval for this.<sup>6</sup>

Responding to this open letter the directors of Physicians for Human Rights-Israel and of Public Committee Against Torture in Israel posed a series of questions to the chairman of the ethics committee, outlining why they believed that the investigation had not been "a professional, detailed and thorough examination of serious and specific claims raised in the Report" (see Web Extra material on *bmj.com*). They requested confirmation that investigations had included "inquiries beyond the telephone conversations mentioned in the letter," such as conversations with doctors working at the hospitals where the prisoners had been treated, reviews of medical files, and documentation of examinations and treatment from the time of arrest. They pointed out that such inquiries would circumvent the inability of many of those providing testimony to name the individual doctors involved and that even the awareness of those doctors that torture had taken place should have led to their reporting the fact to the authorities.

They also challenged the ethics committee chairman's implication that it would be easier to check such allegations were there "some shred of evidence other than the word of the prisoners," pointing out that the denial of an allegation of rape or sexual harassment would not be sufficient grounds for refusing to investigate it. The letter concluded by calling for a comprehensive and exhaustive investigation of the events described in the report, specifically regarding physicians' conduct, and for the IMA to act to instil the rules of medical ethics among physicians in public hospitals and in detention facilities. To date the IMA has not responded to this letter.

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ethics committee, and its members—is whether the security risks facing Israel can be allowed to over-ride human rights. Furthermore, Dr Blachar, as the president of the WMA, had an unparalleled opportunity to re-examine, from a neutral standpoint, the role of the Israeli medical profession in defending human rights. Failure to investigate to the level of accepted international norms could imply an anxiety that the claims have veracity. Furthermore, the BMA should demand from the Israeli Medical Association a more vigorous response in investigating these testimonies. The BMA has put on record its serious concerns regarding reports of medical complicity in torture at Guantanamo Bay and so would not be singling out Israel for censure.<sup>7</sup>

A common response to criticism of Israeli policies or practice is that it is a consequence of antisemitism. Any such comments coming from Jewish critics warrants the label of "self hating Jews."<sup>8</sup> The roots of such interpretations are easy to understand, but, as with the response to the Goldstone report on the Gaza conflict,<sup>9-10</sup> this may merely be an attempt to silence critics. Dr Blachar has written to doctors who are members of Physicians for Human Rights-Israel to say that, because criticism of the IMA expressed in international forums or "slinging mud at the doctors of Israel" provides "fertile ground for anti-Israeli and anti-Zionist anti-Semitism," the IMA has decided to sever all ties with Physicians for Human Rights-Israel, an action that could have dire consequences for the provision of care to some of Israel's most vulnerable groups.<sup>11-13</sup>

The WMA's Tokyo declaration provides a powerful statement on the need to end all medical complicity with torture.<sup>14</sup> The new president of the WMA should work with member associations to develop guidelines on their role in investigating and censoring doctors who contravene this declaration.

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References are in the version on *bmj.com*