"And in My Other Hand…."

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Editor in Chief

This issue of the Journal contains some superb clinical articles that will probably attract your attention first, and will reward you with a wealth of useful information about core clinical topics such as acute stroke, sleep disorders, and diabetes. Also, if you want to live long enough to read all of this, be sure to check out Alan Peterson's always superb section on Top Tips from Family Medicine, this time about how to live longer. And, as we always do whenever feasible, we've coordinated the Imaging Insights section with one clinical article, in this case acute stroke.

But like the magician whose less noticeable hand contains critical information, I'd like to draw your attention away from those obviously important clinical discussions to some equally if not even more pertinent considerations not directly related to patient care.

First, in lieu of our usual Perspective from the Administration, is my separate article which summarizes the activities of the Lancaster Medical Manpower and Education Study Commission, a group with a self-explanatory name, that I am fortunate to Chair. Considering the common predictions of a substantial nationwide shortage of physicians, it is inevitable that we would be concerned about the future supply of physicians for our community. Additionally, LGH is now a major regional medical center with a substantial footprint, and we must also ask not only whether we are fulfilling our responsibilities and potential as an educational institution, but whether those two concerns interface. You can read about it in my article, which recaps and supplements a presentation I made to the meeting of the Medical Staff in February.

Also non-clinical is an important update on the always contentious issue of Mcare, in which Tony Castle, our Senior V.P. for Administration at The Women and Babies Hospital, gives us an insider's perspective from his position as a Trustee of the Pennsylvania Medical Society and Chair of the Pennsylvania Section of the American College of Obstetricians and Gynecologists.

Finally is the superb article from Christopher O'Connor, Associate General Counsel, about the legal controversy surrounding the availability and potential mandatory use of the new human papilloma virus vaccine, Gardasil,™ to prevent cervical cancer.

Aside from the legal issues discussed in his lucid and informative article, we cannot escape the political debate that has surrounded this vaccine because of its purported "moral hazard;" the risk that an entity or individual will behave less responsibly if protected from the consequences of their own actions. Some religious conservatives who feel that sex education should consist entirely of promoting abstinence until marriage assert that Gardasil™ will encourage promiscuity by lessening fear of acquiring HPV and cervical cancer. Supporters of universal vaccination with Gardasil™ respond: "Oh, so you're going to threaten girls with cancer to prevent them from having sex!"

Fortunately, both sides seem willing to throttle back to less extreme positions.[1] Conservatives say they aren't asking for the vaccine to be banned, or even restricted, simply that it shouldn't be mandatory. They point out that HPV infection is not acquired by sitting in a schoolroom, but is the result of a behavioral choice. Parents should have the right to decide what is best for their individual children.

Advocates of Gardasil,™ counter that even if we set aside the basic principle that parents shouldn't be allowed to deny their children a proven health benefit, the argument offered by Gardasil's™ opponents is disingenuous. Too many parents simply can't afford an expensive ($375.) vaccination unless it's provided by the state; in fact, they may not even know about it. Every state already has a law allowing parents to decline vaccination on religious grounds. Given these opt-outs, vaccination advocates say

that "mandatory" is actually just another way of saying "available, affordable, and accessible."

As to the moral hazard, this vaccine must be given to young girls before any exposure to HPV. Advocates point out that when a 9 year old receives the vaccine as part of the routine series of anonymous nuisance vaccinations and boosters that all children endure, the nurse isn't going to tell her "Run along now and have casual unprotected sex, dear; no need to worry any longer."

The concern that many states will make decisions about this vaccine in response to political pressure is partly the result of experience with Emergency Contraception (Plan B®). The FDA, in a highly criticized move widely felt to reflect the Bush Administration's heavy hand, refused non-prescription status for Plan B® despite the fact that the FDA's own scientific advisory committee voted overwhelmingly to grant it.

The New England Journal of Medicine commented:

"*The recent actions of the FDA leadership have made a mockery of the process of evaluating scientific evidence, disillusioned many of the participating scientists both inside and outside the agency, squandered the public trust, and tarnished the agency's image. American women and the dedicated professionals at the FDA deserve better.*"[2]

Supporters of abstinence-until-marriage programs have long claimed that sex education about condoms and birth control encourages teens to have sex—a claim rebutted by scientific research cited by the American Academy of Pediatrics:

"*Current research indicates that encouraging abstinence and urging better use of contraception are compatible goals. Evidence shows that sexuality education that discusses contraception does not increase sexual activity, and programs that emphasize abstinence as the safest and best approach, while also teaching about contraceptives for sexually active youth, do not decrease contraceptive use.*"[3]

The FDA seemed to succumb to the myth of a moral hazard in its decision about non-prescription status for Plan B®, which claimed that it would fuel risky teen behavior. This claim was likewise explicitly rejected by the American Academy of Pediatrics[4] and cited in the NEJM editorial.[2]

"*Data demonstrating that ready access to Plan B® by adolescents as young as 15 did not lead to increased irresponsible sexual behavior were available in December 2003 and had been reviewed by the advisory committee. Moreover, the agency was conspicuously unable, then or later, to cite any data to support different safety or efficacy profiles in different age groups—a damning indictment of the basis for the disapproval.*"

One youth-oriented web site[5] noted wryly: "Clearly, prevention does not cause risky sexual behavior. A vaccine to prevent cervical cancer will not cause promiscuity any more than an umbrella will cause rain or a seat belt will cause an accident."

Regardless of competing claims, cervical cancer now kills almost 4,000 American women annually. In solving this tragedy, let us hope we can find common ground between people of good will. As physicians, we recognize that hard data can be hard to come by and are therefore not always available. Even when available, their interpretation may be contentious. But at least let us also hope, and when appropriate insist, that when unimpeachable data *are* available, decisions about clinical matters will be based on scientific facts.

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The Journal of Lancaster General Hospital publishes articles by members of its professional and administrative staffs.

Articles should usually be between 2,000-2,500 words. Medical articles should describe research at LGH; introduce new diagnostic or therapeutic modalities; discuss notable programs, such as interdisciplinary collaborations that improve therapy; or review complex or controversial clinical issues in patient care.

Anyone wishing to develop an article for publication should contact the Managing Editor Gina Bissett (544-7378; rabisset@lancastergeneral.org). If the proposal is accepted, guidance in developing the article will be provided, and a professional writer will usually be made available to work with the author to develop the final manuscript.

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